

RIVERWOOD THERAPEUTIC RIDING CENTER

ANNUAL VOLUNTEER/STAFF REASSESSMENT FORM

In order to comply with NARHA standards, we must update our volunteer and staff information annually. Please complete **all** information on this form and indicate any changes to your information that may have occurred since you began your service with Riverwood.

Volunteer/Staff Name: _____

Parent Name(s): *(If volunteer/staff is a minor)* _____

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone Number: _____ Work/Cell Phone: _____

E-mail Address: _____

Emergency Contact Person(s): _____

Emergency Contact Phone Number(s): _____

Physician Name _____ Phone _____

Preferred Medical Facility _____

Health Insurance Co. _____ Policy# _____

Are there any recent medical changes that may affect your ability while volunteering/working with us? Please explain:

Volunteer/Staff Signature _____ Date: _____

Parent Signature: *(If volunteer/staff is a minor)* _____ Date: _____