MOONRISE THERAPEUTICS, INC.
VOLUNTEER REGISTRATION FORM

moonrisetherapeutics.org office@moonrisetherpeautics.org (802) 299-8192

FULL NAME ______________________ DATE OF BIRTH ______________

ADDRESS ______________ ______________ ________ ________
Street *City* *State* *Zip Code*

CONTACT INFORMATION ______________ ______________
Phone *Email*

REFERENCES: *List information of <u>at least 1</u> reference (not family members) we may contact:*

REFERENCE 1: ______________ ______________
Name *Phone or Email*

REFERENCE 2: ______________ ______________
Name *Phone or Email*

AVAILABILITY: *i.e. time of day, number of times a week, days of the week* ______________

COMMITMENT DURATION: *i.e. length of time in weeks, months, one time...* ______________

AREAS OF INTEREST:

- ☐ Barn Chores
- ☐ Farm Maintenance
- ☐ Volunteer outreach/support
- ☐ Support during lessons *(side walker or leader)*
- ☐ Exercising horses *(through riding or ground work)*
- ☐ Accounting
- ☐ Fundraising
- ☐ Other: ______________

Do you have any physical limitations that would prevent you from doing any of the following?

- ☐ Leading a horse
- ☐ Sidewalking with a rider
- ☐ Jogging beside the horse
- ☐ Other: ______________

What interests you in volunteering with MoonRise Therapeutics? ______________

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Your signature below certifies the above information is accurate and complete. As a volunteer, I understand that I will be exposed to private health information and agree that this information will not be shared with anyone other than MoonRise Therapeutics, Inc. staff.

YOUR PRINTED NAME ______________________ DATE ______________

YOUR SIGNATURE ______________________

GUARDIAN PRINTED NAME ______________________ DATE ______________
if under 18

GUARDIAN SIGNATURE ______________________
if under 18