

Participant Release Form

Held at: Howard Young Medial Center, Woodruff, WI, September 9 through October 14, 2009

Starred (*) items must be completed. Please print clearly. Your signature is required on the bottom of this page.

Mr. Mrs. Ms. **First Name*** _____

Last Name* _____

Home Street #* _____
Address* Apt #*

_____ City* State* Zip Code*

Birth date _____
 (MM) (DD) (YYYY)

Home Phone (____) _____ Work Phone (____) _____

Email Address _____

Privacy Notice: The Arthritis Foundation respects the privacy of each class participant. To indicate your preferences, fill in the appropriate box.

I would like more information about the Arthritis Foundation: Yes No

May the Arthritis Foundation share your name with other organizations/sponsors? Yes No

I am interested in being an Arthritis Foundation advocate (requires email address): Yes No

I am interested in being an Arthritis Foundation volunteer: Yes No

Do you have arthritis? Yes No

If yes, please select which type: Osteoarthritis/degenerative (OA) Rheumatoid Arthritis (RA)
 Juvenile Arthritis (JA) Other: _____

How did you find out about this program? Flyer Friend Health Care Provider
 Mailing Newsletter Newspaper
 Television Radio Website Other

Ethnic Background: African American Asian American Caucasian
 Hispanic Latino Native American Other

My signature below indicates I have read and accept the Arthritis Foundation Release on page 2 of this form.

(Signature)* (If under 18, parent or guardian must sign)

Today's Date _____
 (MM) (DD) (YYYY)

Participant Release Form

I understand and agree that there are risks, foreseeable and unpredictable, associated with any exercise or education program. I am aware of these risks and agree that my participation is at my own risk. I hereby agree that neither the Arthritis Foundation, nor any co-sponsoring agency or facility, nor their respective chapters, officers, directors, employees, agents, members or volunteers, shall assume or have any responsibility or liability for the expenses or medical treatment or for compensation for any injury I may suffer during or resulting from my participation in the Arthritis Foundation program. I hereby discharge any and all rights and claims for damages that I may have or that may hereafter accrue to me arising out of or in any way connected with my participation in this or any future Arthritis Foundation Program.

I understand that this Participant Release Form has important legal consequences and limits my ability to recover money if I am injured as a result of my participation in this program. I have been given the opportunity to discuss its terms and consequences with an attorney of my choosing if I wish to do so.

I also represent and warrant that I have been advised to seek consultation from my doctor about whether I can safely participate in this program and whether there are precautions or limitations to my participation.

I understand and agree that the goal of the Arthritis Foundation and the co-sponsoring facility is to provide a safe program environment, free from disruption or harassment. To this end, the Arthritis Foundation and the co-sponsoring agency reserve the right to deny admission to those individuals whose behavior is disruptive, or who harass other program members or staff.

I understand and agree that a copy of this form will be provided to the Arthritis Foundation as well as any co-sponsoring agency or facility.

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