



**ARTHRITIS FOUNDATION PACE PROGRAM
PARTICIPANT RELEASE FORM**

Date: _____

(Please print):

Name: _____ Phone: _____
(First) (Last) (area code)

Street Address: _____

City	State	Zip
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Emergency Contact: _____ Phone: _____

Site: _____ County: _____

I understand and agree that there are risks, both foreseeable and unpredictable, associated with any exercise 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 facility organization, nor their respective chapters, officers, directors, employees, agents, members or volunteers, shall assume or have any responsibility or liability for expenses or medical treatment or for compensation for any injury I may suffer during or resulting from my participation in the Arthritis Foundation PACE Program. I do hereby, for myself, and for my heirs, executors and administrators, waive, release, and forever 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 programs.

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.

Signature

Date