Regional Medical Center

FITNESS CLASS

WAIVER FORM

Name: _____ Email Address: _____

Mailing Address: _____ Cell Phone: _____

City: _____ State: ___ Zip Code: _____

PLEASE READ WAIVER CAREFULLY AND SIGN BELOW.

I, _____ (the "Participant") have agreed to participation in Regional Medical Center's fitness class. In consideration of my voluntary participation in the class, I acknowledge that I release Regional Medical Center, the Bob Holtz Wellness Center and staff, sub-contractors, volunteers and supervisors from any and all claims of damage, demands and actions which may arise from my participation in these exercise activities.

Signature of Participant: _____ Date: _____

Parent/Guardian Signature (*if participant under 18*): _____ Date: _____

Absolutely **NO REFUNDS.** If you are unable to participate due to a medical condition a credit will be issued to be used at the Bob Holtz Wellness Center.

STAFF USE ONLY Date Paid _____ Amount Paid _____ □ Check □ Cash □ Credit Card □ Payroll Deduct

Staff Initials _____