Last Mile Ride Motorcycle registration

Yes! I want to ride for end-of-life care.

RIDER INFORMATION

Name: ____

Phone number: ____

Address: ____

City: ______________________ State: __________ Zip: __________

E-mail: ____

Club name (if any): ____

T-shirt size ____________

I'm riding in memory of: ____
(optional)

PAYMENT OPTIONS

☐ Check enclosed
Make check payable to: Gifford's Last Mile Ride

☐ Credit Card

☐ **I am collecting donations**
... and will turn them in at registration

Amount enclosed: $ ____________ *(minimum $50 per person or $75 for driver & passenger)*

Credit card #: ______________________ ☐ Visa ☐ Mastercard CCV #: _____

Expiration date: __________ Amount to charge: ____________

WAIVER

Release of liability: *The undersigned releases Gifford Medical Center, its employees and Last Mile Ride volunteers, sponsors, vendors, entertainers and any others associated with this event from liability for any damage, injury or even death the undersigned may incur or cause while participating in this event. The undersigned is experienced in and familiar in the operation of motorcycles and fully understands the risks and dangers inherent in motorcycling, and agrees to assume responsibility for any resulting harm. This release applies to the undersigned, his or her heirs and other personal representatives, and is an agreement not to sue or file an insurance claim against Last Mile Ride organizers and volunteers. Consent is also given to Gifford Medical Center to use the undersigned's name, image or words in future promotional materials.*

Waiver signature: ______________________________ Date: __________

Return this form to: Last Mile Ride, Gifford Medical Center, 44 South Main Street, Randolph, VT 05060

OFFICIAL USE ONLY

Date received: ____________ Cash __________ Check # ________ T-shirt voucher ___

PLEDGE FORM

Rider name(s): ____

I am riding in memory of: ______________________________________ *(optional)*

I will be participating in the **Last Mile Ride** to benefit palliative and end-of-life care at Gifford Medical Center.

You can help this worthwhile cause. Please consider sponsoring me with a pledge.

Make checks payable to **Gifford's Last Mile Ride.**

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Thank you!

Please check the Tax Receipt box if someone above has requested a receipt for tax deduction purposes. ***Complete addresses need to be printed for tax receipts.***