

# Last Mile Ride Cyclist registration

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



## CYCLIST INFORMATION

Name: \_\_\_\_\_

Phone number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail: \_\_\_\_\_

Team 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*

Credit Card

I am collecting donations

*... and will turn them in at registration*

Amount enclosed: \$ \_\_\_\_\_ (*minimum \$25, but you are encouraged to fund-raise more*)

Credit card #: \_\_\_\_\_  Visa  Mastercard

Expiration date: \_\_\_\_\_ CVV Code: \_\_\_\_\_ Amount to charge: \_\_\_\_\_

## WAIVER

**Release of liability:** *The undersigned releases Gifford Medical Center, its employees and Last Mile 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 bicycles and fully understands the risks and dangers inherent in cycling, 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 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 \_\_\_\_\_

