



2011 Healthy Angels Ride
Registration Form

First Name: _____ Last Name: _____ T-Shirt Size: _____

Passenger's Name: _____ Passenger T-Shirt Size: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Registration Fee: (\$25 single/\$40 two) \$ _____

Sponsor Donations: \$ _____

Total: \$ _____

I, the undersigned, for and in consideration of the opportunity to participate in a "ride," "Dice Run," or "Activity" sponsored and/or conducted by Cass Regional Medical Center Foundation (the "Foundation"), release and hold harmless the Foundation and Cass Regional Medical Center from any and all claims and demands, rights and causes of action of any kind whatsoever which now have or later may have against the Foundation and Cass Regional Medical Center in any way resulting from, arising out of, or in connection with my participation in any said event.

I am experienced in and familiar with the operation of motorcycles and fully understand the risks and dangers inherent in motorcycling. I am voluntarily participating in the event and I expressly agree to assume the entire risk of any accidents or personal injury, including death. I understand that I am responsible for insurance coverage that is required by the Department of Motor Vehicles. I further grant full permission to the Foundation and Cass Regional Medical Center to use any photographs, videotapes, motion pictures, recording or any other record of the event for any reasonable purpose.

PLEASE READ BEFORE SIGNING

Signature of Participant Date

Signature of Guardian (if under 18 years of age) Date

Signature of Passenger (or Guardian, if under 18) Date

If you wish to mail in your registration form, please mail with your check to:
Cass Regional Medical Center Foundation, 2800 E. Rock Haven Rd., Harrisonville, MO 64701