

Return form to Program Leader or send to **1223 Wilshire Blvd #570 Santa Monica CA 90403**  
 Phone: 310/477-8557 **Fax 310/477-4669** **PLEASE PRINT**

I am (check one): \_\_\_ Cancer survivor/ patient \_\_\_ Family member /friend of survivor \_\_\_ Volunteer

<b>First Name</b> _____	<b>Last Name</b> _____	<b>Address</b> _____		
_____ CA _____	<b>City</b> _____	<b>Zip</b> _____	<b>e-mail</b> _____	<b>Birth date</b> _____
<b>Home phone</b> _____	<b>Cell/work phone</b> _____	<b>Profession</b> _____		
		For survivors: <b>Type of cancer</b> _____		
<b>Emergency contact</b> _____	<b>Relationship</b> _____	<b>Phone</b> _____		

Several of our funding agencies require us to ask the following demographic information. This will be used for aggregate grant reporting ONLY. No personal information will be shared with any person or agency. Filling out the following three items is **OPTIONAL**.

<b>Ethnicity:</b>	<b>Total Household income:</b>	<b>How I heard about Team Survivor:</b>
<input type="checkbox"/> African-American	<input type="checkbox"/> under \$30,000	<input type="checkbox"/> doctor, clinic or health care provider
<input type="checkbox"/> Asian/Pacific Islander	<input type="checkbox"/> \$30,000 to \$50,000	<input type="checkbox"/> family or friends
<input type="checkbox"/> Caucasian	<input type="checkbox"/> \$50,000 to \$75,000	<input type="checkbox"/> newspaper, media
<input type="checkbox"/> Latina(o)	<input type="checkbox"/> \$75,000 to \$100,000	<input type="checkbox"/> health fair
<input type="checkbox"/> Other	<input type="checkbox"/> over \$100,000	<input type="checkbox"/> other: _____

**You must sign below & submit form before attending any Team Survivor event.**

**Waiver of Liability:**

I assume all responsibility for any risk of damage or injury that may occur in any programs organized by Team Survivor, including injuries occurring while participating in exercise or movement or while using equipment or facilities. In consideration of being a participant in programs I, or on behalf of myself and my heirs or assigns, hereby release and discharge Team Survivor, its officers, directors, employees, agents and volunteers from all claims, demands, rights of cause of action, present or future, whether known or unknown, anticipated or unanticipated, and resulting from or arising out of incident to my participation in programs. I have read and understand this assumption of risk agreement and release and willingly and without duress sign it, on behalf of myself and my spouse/partner with his/her full consent and approval, and agree to be bound by it.

**The undersigned gives permission that confidential information, including that from medical providers, may be shared with Team Survivor Staff and Program Leaders.**

**The undersigned (if a cancer survivor or patient) is under the care of a medical professional and has been asked to obtain a Medical Release before program participation.**

**X**

**Sign Here** (parent/guardian if under 18 years old)

**Date**