



Saturday, September 11, 2010 MAIL-IN REGISTRATION FORM

Floating Hospital
for Children
at Tufts Medical Center

Must be received by September 6, 2010. Please print clearly and complete ALL fields.
Save a stamp and register online at www.cycleforlife.com!

FIRST NAME _____ LAST NAME _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMAIL _____ PHONE NUMBER _____

TEAM OR TEAM CAPTAIN NAME (IF APPLICABLE) _____

PATIENT PEDAL PAL MATCH

Specific Request _____

Please match me with a Patient Pedal Pal

I am a team captain.

BIRTH DATE _____ AGE ON SEPTEMBER 11, 2010 _____

Gender Male Female Shirt size (Adult) S M L XL XXL

HOW DID YOU HEAR ABOUT CYCLE FOR LIFE? _____

EMERGENCY CONTACT NAME AND TELEPHONE NUMBER _____

WAIVER: I hereby for myself, my heirs, executors and administrators, waive and release any and all rights and claims for damages I may have against Floating Hospital for Children, Tufts Medical Center, and its employees, medical staff and agents, sponsors, the Departments of Parks and Recreations in the towns of Marblehead, Essex, Essex Falls, Manchester-by-the-Sea, Salem, Wenham, Hamilton and Beverly, Massachusetts, Conventures, Inc., coordinating groups, and any individuals associated with the event and their representatives, successors and assigns, and will hold them harmless for any and all injuries suffered in connection with this event. I attest that I am physically fit to participate in this event. I also hereby consent to and permit emergency treatment in the event of injury or illness. I further, hereby grant full permission to any and all of the foregoing to use my likeness in all media including photographs, recordings, or any other record of this event for any legitimate purpose.

PARTICIPANT SIGNATURE _____ DATE _____

PARENT OR GUARDIAN'S SIGNATURE IF PARTICIPANT IS UNDER AGE 18 _____ PRINT PARENT/NAME _____

Registration & Payment Method

- I am registering for the 25-mile ride with \$50 registration fee.
- I am registering for the 50-mile ride with \$50 registration fee.
- I am unable to ride. Please accept my donation of \$ _____ in support of Cycle for Life efforts.

Registration increases to \$75 day of event. All riders receive a T-shirt and each rider who raises \$250 or more receives an official Cycle for Life cycling jersey.

The fundraising minimum is \$150 for 25-mile riders and \$250 for 50-mile riders.

Please note registration fees are not considered donations to the Medical Center, and can not be counted toward your fundraising minimum.

Total Enclosed \$ _____

- My check payable to Cycle for Life/Tufts Medical Center is enclosed.
- Visa MasterCard American Express Discover

CARDHOLDER NAME _____

ACCOUNT NUMBER _____

EXPIRATION DATE _____ TOTAL AMOUNT TO BE CHARGED _____

SIGNATURE OF CARDHOLDER _____

Mail completed form to:
Tufts Medical Center
800 Washington Street, Box #231
Boston, MA 02111

Or fax to: 617-636-7659