VeloRaptors Cycling Club

MEMBERSHIP APPLICATION AND LIABILITY WAIVER

Please mail completed form with the membership fee payable to:

Veloraptors, Kathy Tate, 5333 Terra Granada Dr., #4B Walnut Creek, CA. 94595

(Annual fee is $30 or $40 if paid after March 31; $30 for new members on joining)

PLEASE PRINT CLEARLY

Name_____Phone(H)_____(Cell)_____

Address_____

City_____State_____Zip_____

Email_____

I am applying for Membership in the VeloRaptors Cycling Club (the "CLUB"). The CLUB is a non-profit corporation with a membership that rides together and organizes group rides. During those rides the individual riders are each responsible for their own safety; they are not supervised by the CLUB or its representatives. I understand that it is my personal responsibility to ride carefully, avoid danger, and maintain and understand my equipment.

I understand that cycling is a physical and sometimes dangerous activity which can result in severe injury or death. I understand that I am responsible for my own safety and voluntarily assume the risks of cycling. Because I assume these risks, I release, waive, and discharge the CLUB, and each of its officers, directors and representatives while acting on behalf of the CLUB, from liability for any claim for damages that I, or anyone claiming through me, might have against them for injuries to myself or my property suffered while participating in any CLUB related ride or activity. I understand that this is a release of future and unknown claims, including claims for negligence or carelessness. I nonetheless make this release voluntarily in order to join the CLUB with the full understanding that it will limit my ability to claim damages against the CLUB and its officers, directors and representatives acting in that capacity. However, this release is not intended to limit my ability to claim damages for injury to me or my property against any individual, including a CLUB member, who personally injures me or my property during a Club related ride or activity.

Emergency Contact 1 Name_____Phone #_____

Emergency Contact 2 Name_____Phone #_____

Physician's Name_____Phone #_____

Medical Insurance Carrier/Acct #_____

Known Allergies_____

Your Signature_____Date_____