

Rainbow Vision Quest

October 9 - 11, 2009

PLEASE PRINT, COMPLETE, AND MAIL WITH PAYMENT

Name _____

Address _____

Phone _____

E-mail _____

Emergency Contact Name & Phone _____

Do you need a ride? ___yes ___no

Can you offer a ride? ___yes ___no

Do you have any health issues or disabilities that require special attention? ___yes ___no

Explain:

Do you have a special diet?* ___yes ___no

Explain:

*Although no special meals will be prepared, the eating habits of all participants will be considered in planning meals.

Make check payable to:

GMMC
1213 N Cherokee Ave
Los Angeles, CA 90038

Fee: \$149.00

RELEASE OF LIABILITY

I hereby release and discharge The Gay Men's Medicine Circle and any of its members from any and all liability claims, demands or causes of action that I may hereafter have for injuries or damages arising out of my participation in this workshop. I further agree that I will not sue or make a claim against The Gay Men's Medicine Circle or its members for damages or losses sustained as a result of my participation in this workshop. I assume all the risks encountered due to any acts of nature or any illness occurring in my workshop.

Signature

Date