Participant Registration Form

NOTE: **This form must be completed for all registrants, and all registrants must have a primary care physician in order to be eligible for the Win with Wellness program. Please mail completed registration form to: Memorial Medical Center, ATTN: Win with Wellness, One Atkinson Drive, Ludington, MI 49431. Forms may be faxed to (231) 845-3607 or emailed to: WinWithWellness1@gmail.com**

Gender: M / F **Date of Birth:** ____

Name: ____

Address: ____

City: _________________________ **State:** ______________ **Zip:** ______________________________

Email Address: ____

Phone Number(s):

(Cell) __________________________________ **(Home)** ___________________________

Primary Care Physician: ____

Primary Care Physician Phone Number: (______) __________________________________

Were you referred by a physician? Y / N

Memorial Medical Center cannot provide health screenings without a primary care physician to whom results can be sent for any required medical follow-up.

Biometric Health Screening

July 13 & 14, 2012 in Memorial Medical Center Classrooms, located on lower level off of main admitting lobby.

Please select the date & time you wish to be screened (12 hour fasting is required)

If the screening date/time you select is unavailable, a representative will contact you to schedule a different time.

_________ **Friday, July 13, 2012** _________ **Saturday, July 14, 2012**

Circle screening time: 6:30am 6:45am 7:00am 7:15am 7:30am 7:45am

8:00am 8:15am 8:30am 8:45am 9:00am

Waiver of Liability: In consideration of your acceptance of my participation form, I for myself, my heirs, my executors and administrators, hereby waive any and all rights for claims for loss or damage I may have against the Win with Wellness committee, Memorial Medical Center, any and all persons, entities, or organizations associated with the Win with Wellness program.

Assumption or Risk: I acknowledge that I should contact my personal physician about potential health risks associated with my participation in the Win with Wellness program and that I should receive physician approval prior to participating in the Win with Wellness program. I assume the risk for any medical problems including illness or injury that may develop or worsen as a result of my participation in these events and waive and release all the parties involved with the Win with Wellness program.

____ _______________________________

(Signature of Win with Wellness participant) (Date)