VeloRaptors Cycling Club

MEMBERSHIP APPLICATION

Please mail completed application form with the membership fee payable to:
Veloraptors, Attn: Steve Goldenberg, P.O. Box 13301
Oakland, CA. 94661
(Initial fee for new members is $30. Annual renewal fee is $30 or $25 if paid by end of February)
PLEASE PRINT CLEARLY

Name_______________________________Phone(H)____________(Cell)____________
Address____

City____State_____Zip___________

Email____

In consideration of the acceptance of my application, I, for myself, my heirs, executors, administrators and successors waive, release and discharge all claims for damages resulting from death, personal injury or property damage which I may have, or which may hereafter accrue to me as a result of my participation with this organization. I understand this release is intended to discharge and release, in advance, the Veloraptors Cycling Club, its members and their respective agents, officers, officials, servants and representatives, and any involved municipalities and their respective agents and employees from and against any and all liability arising out of or connected in any way with my participation with this organization even though that liability may arise out of negligence or carelessness on the part of the person or entities mentioned above.

I further understand that serious accidents occasionally occur during bicycle rides and that participants in such events occasionally sustain serious personal injury, death and/or property damage as a consequence of that participation. Nevertheless, knowing the risks of bicycling., I, for myself, my heirs, executors, administrators and successors hereby agree to assume those risks and to release and hold harmless all of the persons or entities mentioned above, who through their negligence or carelessness, might otherwise be liable to me for damages.

I AGREE TO WEAR A BICYCLE HELMET ON ALL CLUB RIDES

Medical Insurance Carrier/Acct #____

Emergency Contact 1 Name________________________________Phone #_____________

Emergency Contact 2 Name________________________________Phone #_____________

Physician's Name____Phone #_____________

Known Allergies____

Your Signature______________________________________Date__________________