Registration Form

☐ MR. ☐ MS. ☐ MRS. ☐ DR.

NAME ____

EMAIL ____

ADDRESS ____

CITY, ST ZIP ____

PHONE ____

I am a... (select one) ☐ Team Captain ☐ Team Member ☐ Individual Walker

TEAM NAME ____

TEAM CAPTAIN _______________________________________

Does your employer have a matching gift program? ☐ YES ☐ NO

EMPLOYER ____

Do you have a retinal degenerative disease? ☐ YES ☐ NO

If yes:

☐ macular degeneration
☐ retinitis pigmentosa
☐ Stargardt disease
☐ Usher syndrome
☐ other retinal degenerative disease

In consideration of being permitted to participate in this event, I voluntarily assume all risks associated with this event, and hereby release the Foundation Fighting Blindness, Inc., its employees and agents, the owner of the premises of this event, and the sponsors of this event, from any and all liability arising from any injury or damage that may be suffered by me or others resulting from my participation in this event. I grant full permission for the use of all recordings of this event.

SIGNATURE OF PARTICIPANT/PARENT/GUARDIAN

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DATE: ________________________

www.VisionWalk.org