

INSTRUCTIONS: 1. Complete form 2. Mail completed form and entry fees to the address at the bottom of the page.

First Name: _____

Last Name: _____

Prov./State: _____ **Postal/Zip:** _____ **Country:** _____

Sex (M/F): _____ **Age:** _____ (On race day)

Email: _____

Shirt Size: XS S M L XL

Day Phone: _____ **Ext:** _____

Address: _____

Apt#: _____ **City/Town#:** _____

Please let us know if you have any medical conditions that we should be aware of:

ENTRY FEES (NO REFUND ON ENTRY FEES)

	Before Feb. 1st	Before Mar. 1st	Before Apr. 15	Race Day	Please Check One:
Half Marathon	\$60	\$70	\$80	\$90	<input type="checkbox"/> Half Marathon
10K Run/Walk	\$40	\$50	\$60	\$70	<input type="checkbox"/> 10K Run <input type="checkbox"/> 10K Walk
5K Run/Walk	\$30	\$40	\$50	\$60	<input type="checkbox"/> 5K Run <input type="checkbox"/> 5K Walk
5K Run/Walk (youth 15 and under)	\$25	\$25	\$25	\$30	<input type="checkbox"/> 5K Run <input type="checkbox"/> 5K Walk (Youth 15 & under)
Kids Dash (7 years and under)	\$15	\$15	\$15	\$15	<input type="checkbox"/> Kids Dash (7 years & under)

In addition to my entrance fee, I would like to make a donation to the Uxbridge Cottage Hospital

I would like to donate: \$10 \$20 \$30 \$40 \$50 \$100 Other: _____ (donations over \$20 will be eligible to receive a tax receipt)

Please make cheques/money orders payable in Canadian Funds to:

Uxbridge Cottage Hospital Auxiliary

If written confirmation is required please include a stamped self-addressed envelope. This waiver must be signed to be accepted.

WAIVER, RELEASE AND INDEMNIFICATION

I know that participating in physical fitness events is a potentially hazardous activity. I agree not to participate unless I am medically able and properly prepared. I should not participate without my physician's approval. I acknowledge that I am solely responsible for my own medical well being. "Event" shall include, but is not limited to, all activities, events or services in any way provided, organized, sponsored or authorized by the "The Run for the Diamond" Organizers. On my own behalf, any minors or third parties for whom I am registering, I agree that (a) we will abide by any decision of an Event official concerning our ability to safely participate; (b) we will assume any and all risks associated with the Event; including but not limited to, falls, contact with other persons or objects, the effects of weather, traffic and course conditions; (c) we hereby consent to permit, and accept responsibility for emergency treatment in the event of injury or illness; (d) we understand if the Event cannot be held as scheduled, we may not be entitled to a refund of any money paid.

As a condition of entering this Event, I for myself, any minors, or any third party for whom I am acting, waive and release Township of Uxbridge, the Uxbridge Cottage Hospital, the Hospital Auxiliary, Hospital Foundation, Administrators, Durham Regional Police Services, Wooden Sticks Golf Course & Wooden Sticks Golf Course Management, all sponsoring companies and any associated or related entities, their directors, officers, employees, agents, representatives, sponsors, volunteers, and organizers ("Event Organizers"), from present and future claims and all liabilities of any kind, known or unknown, arising out of our participation in this Event or related activities, even though such claim or liability may arise out of negligence or fault on the part of the Event Organizers.

We agree that (a) the Event Organizers shall not be liable for any personal injury, death or property loss, and we release the Event Organizers and waive all claims with respect thereto, and (b) to hold harmless and indemnify the Event Organizers, from any and all liability from any property damage or personal injury to any third party resulting from my participation in the Event. We grant permission to Event Organizers to use or authorize others to use our personal information, including but not limited to, any photographs, images or documentation of our participation in this Event or related activities without remuneration being provided to us.

Please select payment option: Cash Cheque Credit Card

Type of Card: Visa Mastercard

Name on Card _____

Account Number _____

Expiry: _____ Security Code: _____ Billing

Address _____

City: _____ Province: _____ PostCode: _____

Print Name: _____

Signature: _____ **Date:** _____

(MM/DD/YY)

17 & under Parent or Legal Guardian

Signature: _____

Register By Mail to:
Uxbridge Cottage Hospital Auxiliary,
4 Campbell Dr.,
PO Box 5003,
Uxbridge
L9P 1S4