KAHLER CYCLING ACADEMY

ERGomania Clinic, 2018

RIDER APPLICATION

NAME: _____ AGE: _____ DATE: _____

E-MAIL ADDR: _____ HEIGHT: _____

CELL PHONE: _____ WK. PHONE: _____

MED. RELEASE NEEDED? _____ LIABILITY SIGNED? _____

TYPE OF CLEATS YOU USE: LOOK KEO _____ SPEEDPLAY _____

SHIMANO SPD _____ SHIMANO ROAD SL _____

ERGomania Clinic Dates: APRIL 24 THROUGH MAY 22

5 TUESDAYS & 2 FLEX-START TIMES: (Please circle One FLEX –START Time)

4:20 to 4:50 PM START OR 5:40 to 6:10 START

ERGomania Clinic Fee is $20 per class CLASSES RUN 50 TO 75 MINUTES

PAYMENT METHOD: CASH or CHECK please

PARTICIPANT'S RECEIPT

NAME: _____ DATE: _____

ERGomania CLINIC DATES: April 24 THROUGH MAY 22

5 TUESDAYS: 4:20 to 4:50 PM START OR
5:40 to 6:10 START

AMOUNT PAID: $_____ BY CASH_____ CHECK #_____

Deposit Paid _____ Balance Due _____

For any questions, please call Robert Kahler at (714) 713-9557

KAHLER CYCLING ACADEMY
Cycling Development & Torture Clinics

LIABILITY RELEASE

I acknowledge that I have voluntarily applied to participate in outdoor bicycle rides, Indoor Cycling Development & Training Clinics, The Torture Prelude Clinic, The Torture Clinic, The Speed & Power Clinic, weight training, exercise and fitness classes, metabolic exercise testing, and other sport and physical exercise activities offered by Santiago Cycling Inc., Mr. Jill's Body Firm, Inc., Robert Kahler, Jill Koval-Kahler, Veloce Santiago and their affiliated organizations and employees.

I AM AWARE THAT PARTICIPATION IN THESE ACTIVITIES IS INHERENTLY DANGEROUS AND INVOLVES A RISK THAT MAY RESULT IN ACCIDENT OR INJURY. I AM VOLUNTARILY PARTICIPATING IN THESE ACTIVITIES WITH KNOWLEDGE OF THE DANGER INVOLVED, AND I HEREBY AGREE TO ACCEPT ANY AND ALL RISKS AND RESPONSIBILITIES OF DAMAGE TO PROPERTY, PERSONAL INJURY OR DEATH.

As consideration for being permitted by Santiago Cycling Inc., Mr. Jill's Body Firm, Inc., Robert Kahler, Jill Koval-Kahler, Veloce Santiago and their affiliated organizations and employees, I hereby agree that neither I nor any of my heirs, guardians or legal representatives will make a claim to against, sue, or attach the property of Santiago Cycling Inc., Mr. Jill's Body Firm, Inc. Robert Kahler, Jill Koval-Kahler, Veloce Santiago and their affiliated organizations and any of their partners, agents or employees as a result of damage to property, personal injury or death resulting from my participation in bicycle rides, Indoor Cycling Development & Training Clinics, The Torture Prelude Clinic, The Torture Clinic, The Speed and Power Clinic, weight training, exercise and fitness classes, and other sport and physical exercise activities offered by Santiago Cycling Inc., Mr. Jill's Body Firm, Inc., Robert Kahler, Jill Koval-Kahler, Veloce Santiago, and their affiliated organizations and employees.

I hereby release Santiago Cycling Inc., Mr. Jill's Body Firm, Inc., Robert Kahler, Jill Koval-Kahler, Veloce Santiago and their affiliated organizations and any of their partners, agents or employees from all actions, claims or demands that either I or my heirs, guardians or legal representatives may now or hereafter have for damage to property, personal injury or death resulting from my participation in these activities.

I HAVE CAREFULLY READ THIS AGREEMENT AND FULLY UNDERSTAND ITS CONTENTS. I AM AWARE THAT THIS IS A RELEASE OF LIABILITY OF SANTIAGO CYCLING INC., MR. JILL'S BODY FIRM, INC, ROBERT KAHLER, JILL KOVAL-KAHLER, VELOCE SANTIAGO AND THEIR AFFILIATED ORGANIZATIONS AND ANY OF THEIR PARTNERS, AGENTS OR EMPLOYEES, AND SIGN IT OF MY OWN FREE WILL.

This Liability Release shall remain in full force and effect until revoked in writing.

Executed on (date) _____ **_____**

(Signature)

_____

(Printed Name)

KAHLER CYCLING ACADEMY

Cycling Development & Torture Clinics
117 N. Prospect
Tustin, CA 92780
(714) 713-9557

MEDICAL CLEARANCE

Required for all new clinic members over the age of 35

You are required to get a physical examination by a physician prior to participating in any exercise program if deemed necessary by physician.

Physician's Approval:
I give medical approval to the person named below to participate in the fitness assessment and exercise program which will include progressive and intensive exercises (aerobic, anaerobic, flexibility, and resistance training) for conditioning the body. I certify that the person whose name is listed below appears to have no reason why a progressive, intensive, exercise program should not be undertaken with the recommendations I have indicated below. Please contact me if there are any concerns.

I AUTHORIZE THE BELOW NAMED PHYSICIAN TO RELEASE INFORMATION NECESSARY TO THE DEVELOPMENT OF MY FITNESS PROGRAM TO Santiago Cycling, Inc.

NAME OF PATIENT: _____

SIGNATURE OF PATIENT: _____

DATE: _____

NOTE TO THE PHYSICIAN:
If the person named above is taking any form of <u>medication</u> that might affect their response to exercise, please indicate below the type of medication, possible effects and precautions when exercising. Also, state any and all types of exercise that this person named above should not do.

_____

_____

_____

Physician Name: _____ Phone: _____

Physician Signature: _____ Date: _____