TORTURE CYCLING CLINIC 2018

CLINIC APPLICATION AND RECEIPT

Clinic Fee: $439.00 (Reduced price from last year!)

(Please Print) **Name:** _____	**Date:** _____
E-Mail Address: _____	
Phone: _____ _____ (Cell) (Work)	**Age:** ____ **Height:**_____
Medical Release Signed? _____ **Liability Signed?** _____	**Info Given?** _____
Cleats for the Monark? LOOK KEO _____ SPEEDPLAY _____ SHIMANO SPD _____ SHIMANO SL ROAD _____	**T-Shirt Size?** _____
Payment Form: Cash $ _____ **Check Number** _____ **$** _____ **($19.00 discount for Cash or Check)** **Master Card, Visa, Amex $** _____ **(No Debit)**	**AMOUNT PAID** **$** _____ **Deposit Received?** **$** _____ **Balance Due: $**_____
CLASS TIME (select one): 5:15 P.M. _____ ***or*** **7:10 P.M.** _____	
SELECT TESTING DATE & TIME: **Wed. Jan. 3rd** _____	**Time: 5:00, 5:40, 6:20**
NOTE: Unscheduled Testings **Thur. Jan. 4th** _____	**Time: 5:00, 5:40, 6:20, 7:00**
may be charged a $25.00 Fee. **Fri. Jan. 5th** _____	**Time: 4:30, 5:10**

TORTURE CYCLING CLINIC 2018

RECEIPT AND TEST TIME

Participant's Name: _____ **AMOUNT PAID**

Payment Form: Cash $** _____ **$_____

Check Number _____ **$** _____ **Deposit Paid? $** _____

MC/VISA, Amex $ _____ **(No Debit)** **Balance Due $** _____

CLASS TIME: 5:15 P.M. _____ ***or*** **7:10 P.M.** _____

TESTING DATE & TIME:	**Wed. Jan. 3rd**	_____	**Time: 5:00, 5:40, 6:20**
IMPORTANT:	**Thur. Jan. 4th**	_____	**Time: 5:00, 5:40, 6:20, 7:00**
Unscheduled Testings May	**Fri. Jan. 5th**	_____	**Time: 4:30, 5:10**
be charged a $25.00 fee.			

NO WORKOUT 1st NIGHT

ORIENTATION: Tuesday, January 2nd, 2018 - 6:00 P.M

*** New Clinic Members Required ***

1st workout w/ bike – Jan 9th

SPECIAL NOTE:ALL FEES ARE NON-REFUNDABLE AFTER JANUARY 2nd, 2018

Questions? Please call Robert at Kahler Cycling Academy in Tustin - (714) 713-9557

KAHLER CYCLING ACADEMY

Santiago Cycling, Inc.

LIABILITY RELEASE

I acknowledge that I have voluntarily applied to participate in bicycle rides, exercise and fitness classes, and other sport and physical exercise activities offered by Kahler Cycling Academy, Santiago Cycling, Inc., Veloce Santiago, Inc. and their affiliated organizations.

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 OF DAMAGE TO PROPERTY, PERSONAL INJURY OR DEATH.

As consideration for being permitted by Santiago Cycling, Inc., Veloce Santiago, Inc. or one of their affiliated organizations, to participate in these activities and to use their facilities, I hereby agree that neither I nor any of my heirs, guardians or legal representatives will make a claim against, sue, or attach the property of Santiago Cycling, Inc., Kahler Cycling Academy, Mr. Jill's Body Firm, Inc., Veloce Santiago, Inc., Gears Over Gravity, Inc, their affiliated organizations, or any of their partners, agents or employees, including Robert Kahler and Jill Koval Kahler as a result of damage to property, personal injury or death resulting from my participation in bicycle rides, exercise and fitness classes, or other activities that they may offer. I hereby release Kahler Cycling Academy, Santiago Cycling, Inc., Veloce Santiago, Inc., their affiliated organizations, and their partners, employees and agents from all actions, claims or demands that either I or my heirs, guardians or legal representatives may now or hereafter have for damage of 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 KAHLER CYCLING ACADEMY, SANTIAGO CYCLING, INC., THEIR AFFILIATES, AND THEIR PARTNERS, AGENTS AND EMPLOYEES, AND I SIGN IT OF MY OWN FREE WILL.

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

Executed at Tustin, California on (date) _____

_____

SIGNATURE

_____

PRINT NAME

Santiago Cycling, Inc.
Kahler Cycling Academy
Robert Kahler

117 N. Prospect Av.
Tustin, Ca. 92780
Phone:(714) 832-1865
Fax: (714) 204-0357

MEDICAL CLEARANCE

This prospective Cycling Clinic student is required to get a physical examination by a physician prior to exercising in this program - if deemed necessary by the 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 KAHLER CYCLING ACADEMY

Name of Patient: _____

Signature of Patient: _____

Date: _____

You also may FAX this completed form to Kahler Cycling: FAX # 714 204 0357

NOTE TO THE PHYSICIAN:

If the person named above is taking any form of medication that might affect his or her response to exercise, please indicate below the type of medication, possible effects and precautions when doing so. **Also,** please state any and all types of exercise that the aforementioned person should not do.

Thank You

_____

_____

_____

_____

Physician's Name **Physician's Phone Number**

_____

Physician's Signature **Date**