

Membership Application

LAST NAME / SURNAME / FAMILY NAME:

FIRST NAME / GIVEN NAME:

MIDDLE INITIAL / NAME:

TITLE / OFFICE:

ADDRESS LINE 1 (APARTMENT OR SUITE NUMBER):

ADDRESS LINE 2 (HOUSE / BUILDING NUMBER, STREET NAME):

OTHER ADDRESS INFO (FLOOR NUMBER, BUILDING NUMBER, MAIL STOP):

CITY:

STATE / PROVINCE:

MALE

FEMALE

HOME PHONE NUMBER:

ZIP / POSTAL CODE:

WORK PHONE NUMBER:

CELL PHONE NUMBER:

FAX NUMBER:

E-MAIL:

NO DENOMINATION: _____

ARE YOU A MEMBER OF A CHURCH? YES CHURCH: _____

I AGREE TO RELEASE The Assist Local Network, its affiliates, directors, pastors, elders, officers, staff, employees, volunteer workers, attorneys, agents, representatives, affiliates, successors-in-interest, and assigns (collectively "PROVIDERS") from all liability, in excess of the applicable limits of any insurance providing coverage to Providers, for injury of any kind, death, and property loss and damage that arises out of or results from the activities and events, including all liability which results from the Negligence of Providers, or any other person or cause.

I hereby grant the Assist Local Network permission to use my likeness in a photograph in any and all of its publications, including website entries, without payment or any other consideration. I understand and agree that these materials will become the property of the Assist Local Network and will not be returned. I hereby irrevocably authorize the Assist Local Network to edit, alter, copy, exhibit, publish or distribute this photo for purposes of publicizing the Assist Local Networks's programs or for any other lawful purpose. In addition, I waive the right to inspect or approve the finished product including written or electronic copy, wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photograph.

In the event of my injury, while I participate in events and/or activities with which The Assist Local Network is associated, I authorize any person connected with The Assist Local Network, to administer first aid, as they deem necessary. I authorize medical and surgical care and transportation to a medical facility or hospital for treatment necessary for the participant's well-being, at my expense.

I agree to submit any claim or dispute that arises out of or results from any activity or event or this agreement to mediation and, if mediation is not successful, to legally binding arbitration. The mediation and legally binding arbitration will be conducted in accordance with the Rules of Procedure for Christian Conciliation of the Institute for Christian Conciliation. Judgment upon an arbitration award may be entered in any court otherwise having jurisdiction.

I hereby hold harmless and release and forever discharge the Assist Local Network from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization. I acknowledge this agreement is governed by the applicable laws of the State of California. If any provision of this agreement is held in whole or in part to be unenforceable for any reason, the remainder of that provision and of the entire agreement will be severable and remain in effect.

I acknowledge that all information that I have disclosed in this membership application is correct and true, and I HAVE READ, UNDERSTAND, AND VOLUNTARILY AGREE TO THIS MEDIA RELEASE, LIABILITY RELEASE, MEDICAL RELEASE, AND MEDIATION AND ARBITRATION AGREEMENT.

Applicant's Signature: _____ Date: _____