



Chilly Bones 5K Classic

Ohio Orthopedic Center of Excellence Foundation

Saturday, November 6th @ 10:00 a.m.

Registration 8:30 – 9:30 a.m.

Location: OOCE, 4605 Sawmill Road, Upper Arlington, OH 43220

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Shirt Size (check one): Small Medium Large XLarge XXLarge

Age: _____ (day of race) Male Female

Registration Fees _____

\$25.00 - on or before 10/16/10

\$30.00 - after 10/16/10

Method of Payment _____

- Cash
- Check Enclosed (made payable to OOCE Foundation)
- Credit Card # _____

Credit Card Type (check one): Visa MasterCard Discover American Express

Exp. Date: _____ Authorized Signature: _____

You may register _____

- By phone @ 614.827.1040 with credit card
- Email registration form & credit card info to dberry@ohio-ortho.com
- Fax registration form & credit card info to 614.827.8671
- Online @ www.premierraces.com
- Mail registration form and payment to: OOCE Foundation
Attn: Denise Berry, 4605 Sawmill Road, Upper Arlington, OH 43220
- Day of race: Registration @ OOCE between 8:30 – 9:30 a.m.

Emergency Contact Name & Phone # (required) _____

Waiver and Release:

I agree that if I participate in this physical activity, program or event (the "Event") or use any Event facility or Event premises, I do so at my own risk. I agree that I am voluntarily participating in the Event and using Event facilities or premises and assume all risk of injury, illness, damage or loss to me or my property that might result, including without limitation, any loss or theft of personal property. I hereby consent to medical treatment in the event of injury, accident and/or illness during the Event. I agree on behalf of myself (and my personal representatives, heirs, executors, administrators, agents, and assigns) to release and discharge Ohio Orthopedic Center of Excellence, Ohio Orthopedic Center of Excellence Foundation, City of Upper Arlington, City of Columbus, Perry Township and all Event sponsors & volunteers from any and all claims or causes of action (known or unknown) arising out of their negligence. I understand that I may be photographed and agree to allow my photo, video or film likeness to be used for any legitimate purpose by the aforementioned parties. The entry fee is non-refundable. I acknowledge that I have carefully read this Waiver and Release and fully understand that it is a release of liability. By my signature below, I am waiving any right that I may have to bring legal action to assert a claim against Ohio Orthopedic Center of Excellence, Ohio Orthopedic Center of Excellence Foundation, City of Upper Arlington, City of Columbus, Perry Township, and all Event sponsors & volunteers for their negligence.

Signature of Participant (or parent/guardian if under 18 years of age) _____ Date _____

Contact Person: Denise Berry @ 614.827.1040 or dberry@ohio-ortho.com