

The Valley Spokesmen Bicycle Touring Club Membership Application

Please complete and return to the following address: **Valley Spokesmen, P.O. Box 2630, Dublin, CA 94568-0784**

I want to join/rejoin the Valley Spokesmen Bicycle Touring Club. **NEW MEMBER** **RETURNING MEMBER** Enclosed is **\$22.00 for a 2012 individual membership** (\$11.00 after June 30th) OR **\$30.00 per year for a 2012 family membership**. (\$15.00 after Jun 30th). **Make check payable to: Valley Spokesmen**

I prefer receiving my newsletter via the **V.S. Web Site** rather than a mailed hard copy

Please add my e-mail address to the V.S. e-mail list so I receive current club information, ride updates, etc.

E-Mail address: _____ Your e-mail address **will not be shared** with any other group or organization

NAME (please print) _____ PHONE (_____) _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

VALLEY SPOKESMEN BICYCLE TOURING CLUB AND LEAGUE OF AMERICAN BICYCLISTS ("LAB") RELEASE AND WAIVER OF LIABILITY, ASSUMPTION OF RISK, AND INDEMNITY AGREEMENT ("AGREEMENT")

In consideration of being permitted to participate in any way in Valley Spokesmen Touring Club ("Club") sponsored Bicycling Activities ("Activity") I for myself, my personal representatives, assigns, heirs, and next of kin:

1. **Acknowledge**, agree, and represent that I understand the nature of Bicycling Activities and that I am qualified, in good health, and in proper physical condition to participate in such Activity. I further acknowledge that the Activity will be conducted over public roads and facilities open to the public during the Activity and upon which the hazards of traveling are to be expected. I further agree and warrant that if at any time I believe conditions to be unsafe, I will immediately discontinue further participation in the Activity.

2. **Fully understand** that: (a) **bicycling activities involve risks and dangers of serious bodily injury, including permanent disability, paralysis and death ("risks")**; (b) these risks and dangers may be caused by my own actions, or inactions, the actions or inactions of others participating in the Activity, the condition in which the Activity takes place, or **the negligence of the "releasees" named below**; (c) there may be **other risks and social and economic losses** either not known to me or not readily foreseeable at this time; and **I fully accept and assume all such risks and all responsibility for losses, costs, and damages** I incur as a result of my participation in the Activity.

3. **Hereby release, discharge, and covenant not to sue, and agree to indemnify and save hold harmless** the Club, the LAB, their respective administrators, directors, agents, officers, volunteers, and employees, other participants, any sponsors, advertisers, and, if applicable, owners and leasers of premises on which the Activity takes place, (each considered one of the "releasees" herein) **from all liability, claims, demands, losses, or damages on my account caused or alleged to be caused in whole or in part by the negligence of the "releasees" or otherwise, including negligent rescue operations.**

I have read this agreement, fully understand its terms, understand that i have given up substantial rights by signing it, and have signed it freely and without any inducement or assurance of any nature and intend it to be a complete and unconditional release of all liability to the greatest extent allowed by law and agree that if any portion of this agreement is held to be invalid the balance, notwithstanding, shall continue in full force and effect.

I AGREE TO WEAR A BICYCLE HELMET ON ALL CLUB RIDES.

DATE _____ AGE _____ SIGNATURE _____

If this application is for family membership, please indicate names and ages of all minors who might be included in club activities.

Name	Age	Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature of parent or guardian (needed if applicant is under 18 years of age): _____

MEDICAL INFORMATION – if interested in receiving a Medical Emergency Card

Emergency Contact: _____ (Phone #): (_____) _____

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Physicians Name: _____ (Phone #): (_____) _____

Medical Insurance: _____ (Phone #): (_____) _____

Coverage ID: _____ Group ID: _____

Allergies: _____

Blood Type: Name: _____ Type: _____

Name: _____ Type: _____

Name: _____ Type: _____

Name: _____ Type: _____

Name: _____ Type: _____