



Participant Waiver and Release Form

TIME™ at Home Program

I hereby affirm that I am in good physical condition and do not suffer from any known disability or condition which would prevent or limit my participation in the Program. I have been advised that an examination by a physician should be obtained by anyone prior to commencing the Program. If I have chosen not to obtain a physician's clearance prior to beginning the Program, I hereby agree that I am doing so solely at my own risk

I agree to view the TIME™ Safety Information and Set Up video in its entirety to understand how to set up and participate safely prior to starting the Program.

I understand that the Program is intended to be a general wellness and recreational program. It is not intended as rehabilitation or physical therapy to correct a particular impairment or disability. The Program is not intended to be relied upon as therapeutic or as medical advice. I understand to consult my healthcare provider if I have any medical concerns.

I acknowledge that I have carefully read this "waiver and release form" and fully understand that it is a release of liability. I agree to release and discharge any trainer or instructor delivering the Program from any and all claims or causes of action and I agree to voluntarily waive any right that I may otherwise have to bring a legal action against the trainer or instructor for personal injury or property damage. In consideration for my voluntary participation in the Program, I, my heirs, executors, representatives, administrators, and assigns do hereby waive, release, and discharge (organization name) and University Health Network from any and all responsibilities, liabilities and lawsuits, present or future, and causes of action for ordinary negligence, whether foreseeable or unforeseeable, arising out of or related in any manner directly or indirectly, to my participation in the Program. I certify that I have read this form and have had any questions answered to my satisfaction.

By agreeing to this document, I am waiving certain rights I or my successors might have to bring a legal action or assert a claim against (organization name) and University Health Network.

Name of participant (please print)

Date: _____

I confirm that I have read, understand and agree to the above