

new beginning therapeutic services llc.

RELEASE, WAIVER, INDEMNIFICATION AND HEALTH AFFIRMATION

By signing this Release, Waiver, Indemnification and Health Affirmation below, I intend to be legally bound hereby, for myself, my minor children, and my heirs, executors and administrators. For and in consideration of participating in *an independent water aerobics course/independent water aerobic/open swim time* (hereinafter referred to as the "Program") at new beginning Therapeutic Services, LLC located at 371 Noah Drive, Suite 102, Jasper, Georgia 30143 (hereinafter referred to as "New Beginning"), I acknowledge and agree to the following:

I hereby acknowledge and agree that my participation in the Program is strictly voluntary. I further acknowledge and agree that the Program is not part of therapeutic treatment provided by New Beginning and is not being offered or administered by New Beginning and its employees. I understand and acknowledge that the Program is being offered and administered by independent water aerobics' instructors.

I hereby release and forever discharge New Beginning and its officers, directors, employees and agents from any and all liability and damages arising out of my participation in the Program including, but not limited to, any personal injury, illness, infirmity or disease (including death), or damage to or loss of property, arising out of my participation in the Program. I recognize that certain hazards and dangers are inherent in participation in the Program, and I acknowledge that New Beginning cannot ensure or guarantee that the participants, equipment, premises and/or activities will be free of hazards, accidents or injuries.

I also agree to defend, indemnify and hold harmless New Beginning as well as its officers, directors, employees and agents from and against any and all damages, costs, claims, demands, actions or causes of action sustained by any other person as a result of my participation in the Program whether caused in whole or in part by the negligence of New Beginning.

I certify and attest that my health insurance will cover any medical and hospital expenses that I may incur.

I HAVE READ AND I ACCEPT THE CONDITIONS DESCRIBED ABOVE.

Signature

Date

Name (please print)



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