

2020 WALK OF LIFE® REGISTRATION AND DONATION - OFFLINE FORM

All persons participating in the Cardiac & Pulmonary Rehab Walk of Life must Complete Registration Form

Participant Name _____ Email _____
 Address _____ City _____
 Province _____ Postal Code _____ Home Tel. _____ Other Tel. _____

Payment:

Cash Cheque

1. Make Cheques payable to Walk of Life for Cardiac and Pulmonary Rehab SAINT JOHN SUSSEX

2. Saint John Regional Hospital Foundation will issue tax receipts for donations \$15.00 or more, if donor's name full address is complete and legible

3. To donate online for Saint John or Sussex, please go to www.thegive.ca/events. Charitable Registration #119132363 RR0001

Donations:

1	First Name	Last Name			\$	Check If Tax Receipt Required <input type="radio"/>	
	Suite#/Apt#	Address	City	Prov.			Postal Code
	<input type="checkbox"/> Cash <input type="checkbox"/> Cheque						
	Email	Phone #					
2	First Name	Last Name			\$	Check If Tax Receipt Required <input type="radio"/>	
	Suite#/Apt#	Address	City	Prov.			Postal Code
	<input type="checkbox"/> Cash <input type="checkbox"/> Cheque						
	Email	Phone #					
3	First Name	Last Name			\$	Check If Tax Receipt Required <input type="radio"/>	
	Suite#/Apt#	Address	City	Prov.			Postal Code
	<input type="checkbox"/> Cash <input type="checkbox"/> Cheque						
	Email	Phone #					
4	First Name	Last Name			\$	Check If Tax Receipt Required <input type="radio"/>	
	Suite#/Apt#	Address	City	Prov.			Postal Code
	<input type="checkbox"/> Cash <input type="checkbox"/> Cheque						
	Email	Phone #					
5	First Name	Last Name			\$	Check If Tax Receipt Required <input type="radio"/>	
	Suite#/Apt#	Address	City	Prov.			Postal Code
	<input type="checkbox"/> Cash <input type="checkbox"/> Cheque						
	Email	Phone #					
6	First Name	Last Name			\$	Check If Tax Receipt Required <input type="radio"/>	
	Suite#/Apt#	Address	City	Prov.			Postal Code
	<input type="checkbox"/> Cash <input type="checkbox"/> Cheque						
	Email	Phone #					

By registering as a participant in the Saint John Regional Hospital Cardiovascular Prevention & Rehabilitation 2020 WALK OF LIFE® (herein referred to as WOL) as part of the Cardiac Health Foundation of Canada's National Walk of Life Campaign, I agree physical activity and endurance is required. I will comply with any and all instructions given by the event officials. I give the Saint John Regional Hospital Cardiovascular Prevention & Rehabilitation, Cardiac Health Foundation of Canada (CHFC), its sponsors and their respective affiliates, advertisers, licensees and assigns (collectively Saint John Regional Hospital Cardiovascular Prevention & Rehabilitation), my irrevocable permission to use and reproduce my image and my name as photographed or otherwise recorded at the WOL, in any manner and in all media in perpetuity. For allowing me to participate in the WOL, I RELEASE AND DISCHARGE the Saint John Regional Hospital Cardiovascular Prevention & Rehabilitation and CHFC, and will hold them harmless from any and all claims, injury or expense of any kind which may result from my participation in the WOL, whether resulting from the negligence of Saint John Regional Hospital Cardiovascular Prevention & Rehabilitation and CHFC, organizers or otherwise.

Signature _____
 (Guardian if under 18)

Total Donations
 (this page) \$



CARDIAC HEALTH | **WALK®**
 FOUNDATION OF CANADA | **OF LIFE**