



2017

INDIVIDUAL / TEAM REGISTRATION FORM

MAIL COMPLETED FORM TO

Lompoc Hospital District Foundation
PO Box 883
Lompoc, CA 93438

DROP COMPLETED FORM AT

Lompoc Valley Medical Center Registration
1515 East Ocean Avenue
Lompoc, CA 93436

PRE-REGISTRATION DEADLINE IS OCTOBER 12, 2017

IF REGISTERING AS A TEAM EACH INDIVIDUAL MEMBER OF YOUR TEAM MUST FILL OUT A REGISTRATION FORM.

FIRST NAME : _____ LAST NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____

EMAIL: _____

TEAM LEADER (if applicable)

TEAM NAME (if applicable): _____

T-SHIRT SIZE: YOUTH S YOUTH M YOUTH L ADULT SM ADULT M ADULT L ADULT XL

PAYMENT METHOD: CREDIT CARD CHECK (Make check payable to Lompoc Hospital Foundation)

CREDIT CARD #: _____

EXP DATE: ____ - ____ CVV: _____

CARD HOLDER NAME: _____

I agree to pay the above total amount according to the card issue's agreement.

This is an important and legal Document, read it carefully before signing. I realize that the event is physically strenuous, that there may be adverse weather. I nevertheless wish to compete and assume the risk of any injury at the crowded start, or on the course. I give up any claims for injuries that I sustain, including death, and agree to hold harmless the Lompoc Hospital Foundation, its directors and officers, employees and volunteers, the Lompoc Healthcare District and anyone connected with the race. I agree that the race may use any photographs taken of me without compensation. I have read and understand all of this. I am making this agreement and paying my entry fee in exchange for the privilege of participating in this race and using the facilities provided by the race.

PARTICIPANT SIGNATURE: _____ DATE: _____

If under 18 years of age, you must have a Parent or Guardian's signature.

SIGNATURE: _____ DATE: _____