Waiver & Release of Liability, Assumption of Risk & Indemnity Agreement

I, the UNDERSIGNED, fully understand and agree to the following:

1. **Gilda's Club Madison, Wisconsin, Inc.** will provide *Cancer Transitions: Moving Beyond Treatment* Program, a program for cancer survivors, such as myself, who have recently completed treatment for cancer. This program will meet for 3 hours, every other week. The program will include support group discussions, education on nutrition and other cancer-related topics, and 20-30 minutes of physical exercise that will be guided by an exercise specialist. The exercise specialist will use his on her reasonable, professional judgment in designing the exercise program and will attempt to adjust the physical exercise to meet my personal fitness level and any physical limitations. The purpose of this program is to encourage cancer survivors to optimize their recovery by improving their physical health, knowledge of healthy living practices, and social/emotional health. All references hereafter to the *Cancer Transitions: Moving Beyond Treatment* Program include, without limitation, a reference to the foregoing exercise program.

2. Participation in any exercise program, such as the exercise programs offered in the *Cancer Transitions: Moving Beyond Treatment* program, may result in foreseeable or unforeseeable injury or illness, including, but not limited to, bodily injury, death, disease, strains, fractures, herniations, ruptures, tears, partial or total paralysis, heart attacks, stroke, infection, allergic reaction, and other ailments that could cause physical or mental disability, including serious disability ("Bodily Injury or Illness"). I certify that I voluntarily applied to participate in the *Cancer Transitions: Moving Beyond Treatment* program and m cognizant of all of the inherent dangers of the exercise programs offered and of the basic safety rules for activities connected with the same. I understand that it is not the function, duty or responsibility of the program instructors or exercise specialists to serve as the guardian of my safety.

3. Prior to my participation in the *Cancer Transitions: Moving Beyond Treatment* program, I consulted with my physical regarding my participation in the exercise programs, and my physician advised me that such exercise programs are consistent with my health care regimen and appropriate to my medical condition. My physical also hereby acknowledges that my active cancer treatment was completed at least three weeks, but no more than two years ago.

4. I agree to release **Gilda's Club Madison, Wisconsin, Inc.**, the Cancer Support Community national organization, UW Health, LIVESTRONG®, and anyone associated with these organizations (the "Released parties") from all claims and damages that may occur due to my participation in the *Cancer Transitions: Moving Beyond Treatment* program. I am responsible for all risks through my participation and will not bring legal action against the Released Parties if I have any injuries or damages. If any of the Released Parties incurs losses or damages as a result of my participation in the *Cancer Transitions: Moving Beyond Treatment* program I agree to indemnify such Released Parties. **I AGREE TO PROVIDE THIS INDEMNITY EVEN IF NO ONE OR MORE OF THE RELEASED PARTIES IS PARTIALLY NEGLIGENT, OR IS THE ONLY NEGLIGENT PARTY OR IS GROSSLY NEGLIGENT.**

5. I agree that any claim against LIVESTRONG® regarding my participation in the *Cancer Transitions: Moving Beyond Treatment* program will be governed by the laws of Texas and any claim that cannot be settled by myself and LIVESTRONG® will be exclusively resolved in a state or federal court in and for Travis County, Texas.

I, THE UNDERSIGNED, AM AT LEAST EIGHTEEN (18) YEARS OF AGE, HAVE CAREFULLY READ THIS AGREEMENT, AND FULLY UNDERSTAND ITS CONTENTS AND INTENT. I AM, AWARE THAT THIS IS A BINDING CONTRACT BETWEEN MYSELF, GILDA'S CLUB MADISON, WISCONSIN, INC., THE CANCER SUPPORT COMMUNITY, LIVESTRONG® AND UW Health, AND I HAVE SIGNED OF MY OWN FREE WILL. I FURTHER AGREE THAT IF ANY PROTION OF THIS AGREEMENT IS HELD INVALID, THE REMAINING PORTIONS WILL REMAIN IN FULL FORCE AND EFFECT.

PARTICIPANT *(THE UNDERSIGNED)* SIGNATURE PRINT NAME DATE

DATE OF BIRTH ADDRESS

PHYSICIAN'S ACKNOWLEDGEMENT FOR PURPOSES OF SECTION 3 ONLY:

PHYSICIAN SIGNATURE PRINT NAME DATE