**RELEASE OF RESPONSIBILITY**

**(Participant’s name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ would like to participate in group chair exercise. I acknowledge my participation is voluntary and that I have obtained permission from my primary care physician and received the necessary clearance to participate in exercise, stretching, strengthening, and breathing exercises. Signing this form confirms that neither myself or any legal representative or family members represented by me, will hold \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ nor any employees or volunteers responsible for any illness or accidents which may occur while I am participating in this program. I understand that should any emergency occur, all financial liability incurred due to transport, treatment or extended care resulting from an accident or illness while participating is my sole responsibility.**

**In addition, I understand that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is not considered a skilled healthcare service, and for this reason, employees and contractors are unable to provide health care advice.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Participant or Legal Representative**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Witness/Title**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date**