



FYZICAL[®]

Therapy & Balance Centers

ADULT RELEASE OF LIABILITY

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Release of Liability:

I, _____, shall indemnify and hold harmless, New Day Wellness, LLC, dba Fyzical Therapy & Balance Centers Gainesville/Chiefland and its agents, servants, employees, officers, and directors from any and all liability for accidents, personal injury, or illness, arising or alleged to have arisen out of my participation in any/all activities during the shadowing experience.

Signature _____ Date _____

Witness _____ Date _____