



Angel Care

Supporting and sustaining caregivers.

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A PROGRAM OF



Angel On My Shoulder™

Please complete and return the following enrollment form for consideration of your participation in the **Angel Care Retreat for Cancer Caregivers** (past or current) offered by *Angel On My Shoulder*. You will receive confirmation by mail, phone or e-mail.

Date _____

Your Name _____ Nickname _____

Address _____ Home Phone (____) _____

City, State, Zip _____ Cell Phone (____) _____

Date of birth: ____/____/____ Gender: Male Female Email: _____

May we share your email with other participants? Yes No

Please list any dietary restrictions (vegetarian, gluten-free, allergies): _____

Name of person afflicted with cancer (past or current): _____

Indicate your relationship to person afflicted with cancer: _____

If you are a professional caregiver, please give name and address of the facility you work for:

Facility Name _____

Address _____

City, State, Zip _____

Please give us a brief summary of your situation (past or current): (USE BACK SIDE OR ANOTHER PIECE OF PAPER IF YOU NEED MORE ROOM.) _____

One guest may accompany you to share your room and join us for dinner on Friday evening. If your guest is also a cancer caregiver and wants to participate in the retreat, please have him/her enroll (separate form) as a participant rather than a guest.

Guest's Name (if applicable): _____

Address: _____

Relationship: _____

I agree that *Angel On My Shoulder* shall be the exclusive owner of all rights in any images (defined as all photographs, videos, recordings or other media) taken of me in connection with *Angel On My Shoulder*. I hereby give *Angel On My Shoulder* permission to use, alter and/or license the images for any lawful purpose. I grant this release with no expectation of payment and acknowledge that my inclusion in *Angel On My Shoulder* activities constitutes sufficient consideration. I agree to make no claim against *Angel On My Shoulder* and to indemnify and hold *Angel On My Shoulder* harmless from any and all claims that I may have related to the images. I agree that the authorization and release is irrevocable, worldwide and perpetual, and will be governed by the laws of the State of Wisconsin. I represent and warrant that I am at least 18 years of age and have the full legal capacity to execute this release. If this authorization and release pertains to a minor, the parent or guardian signing below represents and warrants that he/she has the full legal authority to enter into this authorization and release on behalf of the minor.

Signature _____