Medical Release and Member Application

Membership in TEAMSurvivor Madison, Inc. is open to women with any cancer diagnosis.

Name _____Preferred Name _____ Birthdate: Month: ____ Day: ____

I was diagnosed with _____ in _____(year)

Address: _____

Phone:_____ Cell phone:_____ Email: _____
TEAMSurvivor Madison, Inc. will contact you via email unless otherwise specified.

I give permission to share my contact info. (name, address, phone, email) with TSM, Inc. members: **YES or NO (circle one)**

How did you learn about TEAMSurvivor Madison, Inc.?_____

To help us better plan TEAMSurvivor Madison, Inc. programs, please complete the interest inventory below.

Check all that apply: A = Have done or are doing B = Would like to do or learn C = Have coached and/or lead

Activity	**A**	**B**	**C**		**Activity**	**A**	**B**	**C**		**Skills/Experience**	
Aerobic dance					Pilates					Fund raising, grant writing	
Hiking/walking					NIA					Photography, movie making	
Biking					Triathlons					Networking with other organizations	
Golf					Swimming					Graphic designing	
Running					Tai Chi					Volunteer coordinating	
Canoeing/kayaking					Snow shoeing					Web designing/computing	
Dragon boating					Yoga					Accounting/auditing	
Skiing cross country					Others (list on back)					Other (list on back)	

The undersigned, or their designee, agrees to allow TEAMSurvivor Madison, Inc. to identify me as a member of the organization, use my demographic information and name, voice and/or likeness in public communications including but not limited to: printed materials, Web site and advertising.

Signed _____ Date _____

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Dear _____ (physician name):
I, _____ (patient name), wish to participate in the following physical activities and/or training programs offered by TEAMSurvivor Madison, Inc. (**to be completed by patient**):_____

Please list any restrictions that you would recommend for this program (**to be completed by physician**):
Physical limitations: _____

Other restrictions: _____
_____ (patient name) has my approval to participate in this physical activity with the restrictions described above.

Physician's Signature: _____ Date _____

Completion of the Medical Release and Member Application form is required annually for membership in TEAMSurvivor Madison, Inc. Incomplete forms will be returned for completion. Please return completed form to: TEAMSurvivor Madison, Inc., P.O. Box 46603, Madison, WI 53744-6603

Questions?: Email info@teamsurvivormadison.org **www.teamsurvivormadison.org**

6/09