

2nd Annual Wheelchair Air Rifle Championships
Hosted by VA Boston Healthcare System
Brockton, MA

Dear Shooters;

VA Boston Healthcare System is proud to be a part of the 2010 NRA National Disabled Indoor Sectional Championships and we would like to invite you to participate in the **2nd Annual Wheelchair Air Rifle Championships**.

The event will be *Saturday, **March 20, 2010** at 940 Belmont Street (Brockton Campus of the VA Boston Healthcare System) Brockton MA 02301, building 23.*

Schedule

8:00 a.m.	Registration
9:00 – 10:45 a.m.	Relay #1
11:00 – 12:45 p.m.	Relay #2
1:00 – 2:45 p.m.	Relay #3
4:00 p.m.	Dinner and Award Ceremony

Please forward the attached registration form and payment of \$7.50 per athlete (plus \$7.50 per team) by March 5, 2010 to the following address: PLEASE NOTE. There is no charge if you are a Military Veteran. You will be asked to provide a copy of your DD214 at time of registration.

*Owen "Mickey" Emery
15 Temi Road
Bellingham MA 02019-1338*

Please feel free to contact me with any questions or concerns at *Richard.Leeman@VA.Gov* or *774-826-1957*.

We look forward to seeing you.

Sincerely,

*Richard Leeman
Assistant Chief, Voluntary Service*

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(Mr./Mrs./Ms.) _____

First Name _____ **Middle Initial** _____ **Last Name** _____

Date of Birth (M/D/Y) _____ **Age** _____ **Sex** _____ Male _____ Female _____

Street Address _____

City _____ **State** _____ **Zip Code** _____

Telephone Number (Main) _____

Shooting Classification: SH1 Rifle _____ SH2 Rifle _____ Pistol _____

Left-handed _____ **Right-handed** _____

Are you also registering as part of a team? _____ Yes _____ No _____

Team Name _____

Audio Visual Consent: I hereby consent and authorize the taking of photographs, movies, films, videotapes, tape recordings, or reproductions (collectively, "Reproductions") of the persons who are hereby applying for membership (the "Applicants") and consent to use, copyright, license, publication or broadcast of the same for advertising, educational, promotional, or publicity purposes on the part of VA Boston Healthcare System and by its affiliated and associated organizations, including its directors, officers, agents, servants and employees. I hereby grant and assign to the VA Boston Healthcare System the right, title, and irrevocable authority and interest to such Reproductions. I waive any and all claims for compensation and waive any and all claims VA Boston Healthcare System related to or arising out of the publication and dissemination of the same of any lawful purposes. I further authorize the communication of information concerning the undersigned in connection with the utilization of such Reproductions by VA Boston Healthcare System, its affiliated or associated organizations, and their respective directors, trustees, officers, agents, servants and employees without claim for compensation and waive all claims related to or arising out of the publication and dissemination of the same. (initial) _____

Consent for Emergency Treatment: I hereby give permission for the Participant to participate as a participant/volunteer. In the event that the Participant should sustain any injuries while participating in a VA Boston Healthcare System activity or while on the premises of VA Boston Healthcare System, I understand that the Participant may be examined and treated for emergency injuries by health care personnel, including examinations at medical facilities. In voluntarily consenting to such examination and treatment for the, VA Boston Healthcare System its directors, officers, staff, employees, contracted employees, agents and volunteers from any actions, suits, damages, claims, or judgements that may result from such examination and treatment. (initial) _____

Release and Indemnification: I hereby release and discharge VA Boston Healthcare System and all affiliated and associated organizations, together with their respective trustees, directors, officers, employees, and agents, of and from any and all demands, claims, causes of action, suits, damages, judgments, or liabilities of any kind or nature whatsoever, arising out of or in any way related to the Participant's participation in a VA Boston Healthcare System activity, including any personal injury or death, which he/she may suffer or incur as a result of participation in such program, whether or not caused by the negligence or wrongful acts of such persons or any agents, servants or employees of any of them. This release shall be binding upon the heirs, next of kin, guardians, executors, and administrators of the Participant. I do further agree to indemnify and hold harmless each of them, of and from any and all claims, demands or actions of any kind or nature whatsoever arising out of any injury of damages incurred by the Participant. In signing this release, I acknowledge and represent that I am over 19 years of age, I am of sound mind, I have read this release, understand it, and sign it voluntarily, and that this release contains the entire agreement between myself and VA Boston Healthcare System. (initial) _____

I have read, understood, and completed this questionnaire. Any questions that I had were answered to my full satisfaction.

Signature Participant

Date

Signature (Parent / Guardian if under 18)

Witness