

PUSH THE PACE.COM

PERSONAL COACHING WAIVER

I voluntarily choose to utilize the personal coaching service of **PUSHTHEPACE.COM** in order to improve my training and racing. I understand that the training philosophy of **PUSHTHEPACE.COM** service is to understand my needs as a runner and develop a program that best fits with my personal goals. I also understand that this training philosophy may create certain potential risks such as abnormalities in my blood pressure, breathing, heart rate, and/or muscular-skeletal system that cannot be predicted with complete accuracy. I understand that I am responsible for monitoring my own condition throughout the training program developed by this personal coaching service which I have chosen and agreed to undertake, and should any unusual symptoms or conditions occur, I will immediately cease following the training program and inform my coach of the symptoms or condition.

In stating that I agree to this agreement and waiver of liability, I acknowledge that I have read this form in it's entirety and that I understand the potential risks associated with the personal coaching service. I also agree to consult with and obtain written permission from my primary care physician prior to undertaking this new training program. If I do not consult with and obtain permission from my primary care physician, I accept any and all consequences that may result from this inaction on my part.

Finally, in consideration for being allowed to participate and choosing to engage in this training program, I agree to assume the risks of such training, and further agree to hold harmless **PUSHTHEPACE.COM** coaching service from any and all claims, suits, losses, and/or related causes of actions and damages, including, but not limited to, such claims that may result from my injury or death, accidental or otherwise, during or arising from, these personal coaching services.

Print Name: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

Physician's Name: _____ Physician's Phone: _____

Please list any medical limitations and/or medications used: _____

Please complete form and mail to:

Todd Williams 289 Sparrow Branch Circle Jacksonville, FL 32259