



Multiple
Sclerosis
Foundation

HEALTH AND WELLNESS GRANT

GROUP PROGRAM APPLICATION AND RELEASE

(Please Print)

Last Name _____ First Name _____

Street _____ Apt. _____

City _____ County _____ State _____ Zip _____

Date of Birth _____ Phone _____ Email _____

Emergency Contact _____ Relationship _____ Phone _____

Physician's Name _____

Physician's Fax _____ Phone _____

When were you diagnosed with MS? _____ Current Major Symptoms _____

Is it OK for us to leave a detailed message about this application on your voice mail or with another household member, if you are not available? Yes No

Please include a written confirmation of diagnosis of MS from your physician.

The Recipient accepts the above described goods and/or services. The Recipient understands and acknowledges that the Multiple Sclerosis Foundation is a charitable organization which does not have direct control or involvement in the provision of the goods or services and cannot bear liability for any claims, damages or injuries resulting from the Recipient's acceptance of the goods or services. Accordingly, the Recipient hereby indemnifies, releases and holds the foundation harmless from, against and in respect of all damages, including any claim, action, demand, loss, cost, expense, liability, penalty or other damage, including, without limitation, attorney's fees and other costs and expenses reasonably incurred in investigating or in attempting to avoid same or opposing the imposition thereof or in enforcing this indemnity and release, resulting to the Recipient from the treatment, care or other goods or services provided to the Recipient by or through the Multiple Sclerosis Foundation.

(Parent/Legal Guardian of 'Children under 18', please write the child's name and Sign below).

Applicant/Guardian's Signature _____ Date _____

National Headquarters: 6520 North Andrews Avenue, Fort Lauderdale, Florida 33309-2132

National Toll-Free Helpline: 888-673-6287 • Fax: 954-351-0630

support@msfocus.org • www.msfocus.org