



Safety and Education Program REGISTRATION FORM

All fees to be paid in advance.

Course / Event: BFSC RSO Basic Rifle Basic Shotgun WIS

Other: _____ Date: ____/____/____

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Telephone: _____ **Emergency Phone:** _____

Mass. Rifle Association Membership Number (if applicable): _____

Date of Birth: ____/____/____ **Email:** _____

Please note any special needs / issues:

Have you have shot before: No Yes If yes: Pistol Rifle Shotgun

Health Insurance Company / Policy Number:

I hereby, for myself, my heirs, executors and administrators, waive and release any and all rights and claims for damages that I may have against the Massachusetts Rifle Association ("MRA") and its representatives, officers, employees and members for any and all injuries suffered by me at these activities. I acknowledge that these activities have a risk of physical injury, which I am willing to assume. I consider myself to be in appropriate physical condition to participate in these activities. I hereby grant permission to an attending physician and his/her staff to provide such treatment, medical and/or surgical procedures as may be deemed necessary or advisable. I understand that in an emergency, whenever possible, all attempts will be made to communicate with me prior to use of this permission by a medical provider(s). I further give the MRA permission to use my image or likeness taken on MRA property by film, video, digital or other means.

Signature: _____ **Date:** ____/____/____