The Burke Restorative Neurology Clinic

Liability Waiver

I,_____wish to enroll in the Restorative Neurological Clinic at The Burke Medical Research Institute. I understand that exercising in this program may involve a variety of physical activities including, but not limited to stretching, Range of Motion and strengthening with motorized robotic devices. I understand that participation in this program is voluntary and not medically prescribed therapy. I hereby affirm that I do not now suffer, nor have I ever suffered, from any medical condition, impairment or disability that would prevent or limit in any way my participation in this program.

I fully understand and assume risk that I may suffer injury as a result of my participation in the Restorative Neurological Clinic. These risks include, but are not limited to, changes in blood pressure or heart rate, dizziness, muscle strain or pulls, soreness and in rare cases serious illness such as heart attack. There is some risk of injury to bones, joints, and/or muscles. I am willing to assume such risk. My physician approves of my participation in this program.

In consideration of my participation in The Restorative Neurology Clinic, I for myself, my heirs, executors, administrators, representatives and assigns hereby discharge The Burke Restorative Neurology Clinic, it's employees, subsidiaries, affiliates, offices, directors, agents, successors, assigns, and/or representatives, from any and all claims, demands, causes of action, suits, charges, liabilities, and expenses (including attorney's fees) of any nature whatsoever, now or in the future, arising from my participation in the Restorative Neurological Clinic program including but not limited to liability related to the injuries listed above, however caused, whether they occur during or after my participation in these programs.

I hereby affirm that I have read and fully understand the above, and that my signing of this waiver is knowing and voluntary.

DATE_____SIGNATURE_____