COMMONWEALTH CLYDESDALE HORSE SOCIETY
AUSTRALIA Inc.
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CCHSA MEMBER'S INDEMNITY FORM

CCHSA BRANCH:.....

EVENT TITLE:.....

NAME OF MEMBER: .....

MEMBERSHIP NO: .....

POSTAL ADDRESS: .....

..... **POSTCODE:** .....

TELEPHONE: .....

EMAIL:.....

I agree and consent to being a participant in the above outlined event. I hereby also agree to release, discharge and to hold CCHSA Inc. harmless for any accidents, harm and/or loss, which I may suffer as a result of participating in the outlined event.

In addition, I hereby agree to indemnify the CCHSA Inc. and its servants, volunteers and agents for any loss, demands, damages, expenses, claims, actions and suits brought for and on behalf of myself and arising out of or in any way connected to the outlined event.

I authorize CCHSA Inc. to obtain any medical or hospital treatment as in its opinion may be required for myself. I agree that this indemnity shall extend to the decision of the CCHSA Inc. to obtain or administer such medical treatment and I further agree to pay the costs of such treatment.

In the event of there being any known medical conditions for myself or the need for taking of medication which would affect the rendering of any urgent medical assistance, I give consent that my details be recorded below and kept in a confidential manner by the above-named group organising this event.

Known Allergies: .....

Medication: .....

.....

Signature: ..... Date: .....