

# THE ENDOWMENT FOR MEDICAL RESEARCH

## RELEASE and INDEMNIFICATION FORM

***WE STRONGLY RECOMMEND THE  
BENEFACTOR, SPOUSE, LEGAL GUARDIAN, AND/OR PARTICIPANT PRINT A COPY OF THIS FORM FOR THEIR RECORDS.***

The individual, as listed below, has my permission to fully participate in The Endowment for Medical Research proposed pilot survey and to participate in all activities associated with the program. I represent that I am lawfully acting in the capacity as the spouse and/or natural or legal guardian of the named individual.

In connection with and in consideration of the individual's participation in the program, I, on behalf of this individual and myself, my heirs, personal representative(s) and assigns, hereby represent and agree as follows:

- 1) I am aware that the individual will be participating in a program which includes Nutritional Supplementations, which will be provided through The Endowment for Medical Research, a 501(c)(3) non-profit public charity. I am further aware that the nutritional supplements being provided for use in the program consist of natural ingredients, and an ingredient list has been provided for my review. I have been informed that there are no known side effects from consumption of these food supplements other than such allergic reactions as might result from any listed food contained therein.
- 2) I understand that the program also includes educational elements regarding elimination of foods that may cause certain symptoms, optional recommended tests such as hair analysis, drinking water, and techniques to help strengthen the mental activity and help build mental confidence.
- 3) I understand that the individual is not in any way required to participate in the Program, but is able to participate and I consent to his/her participation and completion of the Program.
- 4) To the fullest extent permitted by law, I hereby release and forever discharge, and agree not to sue and do hereby indemnify and hold harmless The Endowment for Medical Research, its founder, webmaster, coordinators, staff or volunteers from and against any and all liabilities, claims, demands and causes of acting of any kind on account of any loss, damage, illness, or injury to person or property in any way arising out of or relating to participation in the program and/or related activities, whether due to the negligence, mistake, or other action or inaction of The Endowment for Medical Research or any other person or entity.

**I CERTIFY THAT I AM AT LEAST 18 YEARS OLD,  
THAT I HAVE READ AND FULLY UNDERSTAND THIS RELEASE AND INDEMNIFICATION FORM, AND  
I SIGN IT VOLUNTARILY WITH FULL KNOWLEDGE OF ITS SIGNIFICANCE.**

.....  
Print Name of Participating Individual: \_\_\_\_\_

Age \_\_\_\_\_

Signature of Participating Individual: \_\_\_\_\_

Date \_\_\_\_\_

***IF APPLICABLE:***

Print Name of Spouse/Legal Guardian Having Care and Custody of Participating Individual: \_\_\_\_\_

Signature of Spouse/Legal Guardian Having Care and Custody of Participating Individual: \_\_\_\_\_

Date \_\_\_\_\_

Emergency Telephone (\_\_\_\_\_) \_\_\_\_\_ E-mail Address \_\_\_\_\_

FORM REVISION DATE: 4/21/2006

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