

NEW YORK CITY AIKIDO / TASL ARTS LLC

PARTICIPANT INFORMATION FORM

NAME (First Middle Last): _____

ADDRESS: _____

CITY / STATE / ZIP: _____

PHONE: _____ EMAIL: _____

DATE OF BIRTH: _____ GENDER: _____

AIKIDO RANK: _____ DAN KYU Year started: _____

DATE OBTAINED: _____ ORGANIZATION: _____

OTHER MARTIAL ARTS: _____

If you have any allergies, physical limitations, medications or medical conditions of which the dojo should be aware with regard to your safety while training or the safety of others, please explain them briefly. If these limitations may affect your training or the training of others, you are responsible for making the class instructor aware of them. _____

EMERGENCY CONTACT Name: _____

Relationship: _____ Phone: _____

I certify that all the above information, to the best of my knowledge, is true, correct and complete.

SIGNATURE: _____ **DATE:** _____

OFFICE USE ONLY v1.0 Interview _____ Form taken by _____

Member Visitor Waiver _____ Data entered _____