



DELOITTE TEAM IN TRAINING REGISTRATION FORM

The Leukemia & Lymphoma Society, New York City Chapter, 475 Park Avenue South, 8th Floor, NY, NY 10016
Phone: (212) 376-6742 Fax: (212) 376-7095 www.teamintraining.org/nyc

First Name _____ Last Name _____ Birth Date ____/____/____

Address (preferred mailing address) _____

City _____ State _____ Zip _____

Eve Phone _____ Day Phone _____ Mobile _____

Email _____ Fax _____

Employer: Deloitte Position/Title _____

Who referred you from Deloitte _____

Sex Male Female T-shirt size XS S M L XL XXL

City/County/State in which most of training will take place (Circle One) : Manhattan Brooklyn Staten Island Other _____
*other chapter areas (Northern NJ, Westchester/Hudson Valley, Long Island)

Training level (if known) Run or Walk _____ minutes per mile Cycle _____ miles per hour

EVENT AND REGISTRATION INFORMATION

As a TNT volunteer supporting The Leukemia & Lymphoma Society and its mission, I hereby agree to train for and participate in the following event and to raise the designated Fundraising Minimum by approximately two weeks prior to my travel date.

- Nike Women's Half Marathon (13.1 miles) October 18 \$3,900 run run/walk walk
- Nike Women's Full Marathon (26.2 miles) October 18 \$3,900 run run/walk walk
- Marine Corps Marathon (26.2 miles) October 25 \$3,200 run run/walk
- El Tour de Tucson November 21 \$4,500 Bike 100 miles 70 miles

Registration Fee: Registration fee of \$50 is applied towards your fundraising minimum.

- Enclosed is my check for the \$_____ non-deductible/non-refundable/non-transferable registration fee (payable to **The Leukemia & Lymphoma Society**)
- Please charge my credit card for the \$_____ non-deductible/non-refundable/non-transferable registration fee

Card Number _____

Exp. Date _____

Name as it appears on card* _____

Signature _____

**This information must be personally provided and signed for by the cardholder.*

RECRUITMENT INFORMATION

How did you hear about the Team In Training program? Identify primary source only:

- I am a past participant (marathon / century / triathlon: event & year completed) _____
- Referred by a family member, friend or TNT past participant (please name) _____
- Direct Mail Brochure / flyer (location) _____
- Radio (station) _____ Gym Tabling (location) _____ Seagate
- Article _____ Magazine / Newspaper Ad (publication) _____ Nike P.F. Chang's
- Subway or Bus Ad PowerBar American Airlines Other _____

PERSONAL CONNECTION If you have someone in whose honor or memory you wish to train, please share. This is not limited to blood cancers.

NAME _____ IN HONOR OF / IN MEMORY OF (Circle One)

If you'd like us to send your Honored Teammate (or his/her family) an acknowledgement of your participation, please include recipient's name & address: _____

FOR OFFICE USE ONLY: Mtg _____ WC _____ SC _____ Paid _____ Paycor _____ Reg Mat _____ FE _____ Mentor _____



MEDICAL, FITNESS AND EMERGENCY INFORMATION

Please complete this form completely and return to the New York City Chapter's office before your first day of training.

Name _____ Event Name _____

Address _____

City _____ State _____ Zip _____

Day Phone _____ Eve Phone _____ Fax _____

MEDICAL INFORMATION

Medical Insurance Company _____ Insurance ID# _____

Current Medications _____

Condition Requiring Medications _____

Allergies (food, medications, etc.) _____

Have you experienced any of the following symptoms in the last year:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> A Chronic Illness | <input type="checkbox"/> Back Problems | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Trouble Breathing | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Heart Condition (if so, please explain _____) | <input type="checkbox"/> Asthma | <input type="checkbox"/> Unusual Fatigue | <input type="checkbox"/> Liver Condition |

Do you have any condition(s) that might affect your health and safety while training for your endurance event?

Is there anything else, not listed above, that you would like us to know? _____

If any of the above symptoms are checked, that could put you at risk while training, Team In Training will require a note from a physician giving medical permission to participate in any Team In Training program.

FITNESS INFORMATION

Age Range: () 18-25 () 26-35 () 36-45 () 46-50 () 51-60 () Over 60 Date of Birth: ____/____/____

I currently engage in athletic/sports/fitness activities

- Daily 5-6 days/week 3-4 days/week 1-2 days/week Almost Never

List any previous or current athletic injuries _____

I have completed (state number completed)

- Marathon(s) Half-Marathon(s) 10K(s) 5K(s) Century Ride(s) Triathlon(s)

Please describe other races/tours/competitions completed _____

Are you a member of a local gym? If so, which one(s)? _____

EMERGENCY INFORMATION

In case of emergency, please notify _____ Relationship (please circle) spouse / friend / relative

Emergency contact phone Home _____ Cell _____

I am also aware that I must sign the LLS's Liability Release form.

Date _____

Signature of Participant