HIGHMARK®

WALK FOR A HEALTHY COMMUNITY

Highmark is an Independent Licensee of the Blue Cross and Blue Shield Association

REGISTRATION FORM

Last Name: _____

First Name: _____

Age: _____

Address: _____

City: _____

Zip code: _____

Phone: _____

E-mail: _____

If Applicable

☐ I cannot participate, but please accept my donation.
(Please make check payable and mail to your selected organization.

☐ I am employed by a Highmark Health Company.

Employee ID number: _____

Disclosure: I hereby waive all claims against Highmark Health, its affiliates and subsidiaries, and all sponsors, charities, or personnel involved in the walk for any injury that I might suffer at this event. I attest that I am physically fit and prepared for this event. I grant full permission for Highmark Health, its affiliates and subsidiaries, and participating organizations to use photographs of me in the accounts and promotions of this event.

Signature: _____

Date: _____

Parent or Guardian Signature (if registrant is under age 18): _____

Date: _____

T-shirt Size ☐ S ☐ M ☐ L ☐ XL ☐ XXL