TETRAPLEGIA WORKGROUP
c/o Dept of Rehabilitation Medicine, TTSH
Ang Mo Kio Community Hospital
17 Ang Mo Kio Ave 9
Singapore 569766
www.tetraplegiaworkgroup.org

TETRAPLEGIA WORKGROUP INDEMNITY FORM

SECTION A (for patients 18 years and above)

I, ______________________________ (Name of Patient), _____________ (NRIC/Passport No), hereby agree to participate in the activities of the Tetraplegia Workgroup, including, but not limited to home visits and occasional outings. I will not hold Tetraplegia Workgroup responsible for any loss, damage, mishap, accident, injury or loss of life arising directly or indirectly as a result of or in connection with my participation in any of the activities.

________________________ ____________

Signature / Thumb Print of Patient Date

Witness (family member or caregiver)	
Name :	________________________
Relationship :	________________________
Signature :	________________________

SECTION B (for patients who are below 18 years of age or unable to give consent)

I, ______________________ (Name of Patient's Next of Kin), __________ (NRIC /Passport No), hereby give consent for my _________ (Relationship to Patient), ______________ (Name of Patient) to participate in the activities of the Tetraplegia Workgroup, including, but not limited to home visits and occasional outings. I will not hold Tetraplegia Workgroup responsible for any loss, damage, mishap, accident, injury or loss of life arising directly or indirectly as a result of or in connection with my participation in any of the activities.

_________________________ ____________

Signature of Patient's Next of Kin Date