

JOIN T.H.O.R. & SUPPORT LOCAL TRAILS

T.H.O.R. is a non-profit volunteer organization dedicated to developing and maintaining sustainable off-road recreational trails in Eastern Nebraska and Western Iowa, through partnerships with local land managers and trail users, by providing expertise, manpower and resources.

T.H.O.R. TRAILS:

- *BRANCHED OAK SRA
- *JEWEL PARK
- *LAKE MANAWA STATE PARK
- *LEWIS AND CLARK MONUMENT
- *PLATTE RIVER STATE PARK
- *SWANSON PARK
- *TRANQUILITY PARK
- *WILDERNESS PARK

MEMBERSHIP BENEFITS

- *IMPROVED & EXPANDED TRAILS
- *CLUB EVENTS
- *E-NEWS LETTERS

Contributions to T.H.O.R. are tax-deductible to the extent allowed by law.



Trails Have Our Respect

NAME: _____

ADDRESS: _____

CITY: _____

STATE/ZIP: _____

PHONE: _____

E-MAIL: _____

MEMBERSHIP: \$20 (CALENDAR YEAR)

PLEASE ATTACH CHECK PAYABLE TO T.H.O.R. & MAIL COMPLETED FORM TO:

T.H.O.R.
C/O DON RASKEY
1608 OLD GLORY RD.
LINCOLN, NE 68521-1553

www.trailshaveourrespect.org

WAIVER OF CLAIM:

IN CONSIDERATION OF MEMBERSHIP IN **TRAILS HAVE OUR RESPECT** (HERE IN AFTER REFERRED TO AS T.H.O.R.) I, FOR MYSELF AND MY MINOR CHILD/CHILDREN, HEIRS, EXECUTORS, ADMINISTRATORS AND ASSIGNS, HEREBY AGREE TO FOREVER RELEASE AND DISCHARGE ANY AND ALL INJURIES, INCLUDING DEATH AND ANY PROPERTY DAMAGE IN ANY MANNER ARISING OR RESULTING FROM MY PARTICIPATION OR MY CHILD/CHILDREN'S IN ANY ACTIVITY CONDUCTED BY OR IN CONJUNCTION WITH T.H.O.R.

I ATTEST AND VERIFY THAT I HAVE FULL KNOWLEDGE OF THE RISKS INVOLVED IN MOUNTAIN BIKE RIDING AND IN ALL T.H.O.R. ACTIVITIES. THAT I ASSUME THOSE RISKS, THAT I WILL NOT, WITHOUT LIMITATION, ASSUME AND PAY ANY AND ALL MEDICAL AND EMERGENCY EXPENSES INCURRED ON OR BY CHILD/CHILDREN'S BEHALF IN THE EVENT OF AN ACCIDENT, INJURY, ILLNESS, OR OTHER INCAPACITY WHILE PARTICIPATING IN ANY T.H.O.R. ACTIVITY, REGARDLESS OF WHETHER I HAVE AUTHORIZED SUCH EXPENSE. I FURTHER AGREE THAT IN THE EVENT I REQUIRE MEDICAL OR SURGICAL TREATMENT WHILE UNDER THE SUPERVISION OF T.H.O.R. OR ANY OF ITS REPRESENTATIVES, SUCH T.H.O.R. REPRESENTATIVES MAY AUTHORIZE MEDICAL TREATMENT FOR MYSELF.

I HAVE READ AND AGREE WITH ALL TERMS OF THIS WAIVER. (Applicants under the age of 18 require the signature of a parent or legal guardian.)

APPLICACANT SIGNATURE _____ DATE _____

PARENT/GUARDIAN SIGNATURE _____ DATE _____