



ABLE BIONICS USA WAIVER

PERMISSION TO OBTAIN MEDICAL TREATMENT ON MY BEHALF

Should I or the person for whom I am the legal guardianship, become injured or ill, I give permission for Able Bionics USA's program facilitator(s) to render First Aid, initiate CPR if needed, and to seek emergency medical services as they see fit, and at my cost.

Client Name (Print)

Signature

Date

Guardian Name (Print)

