

TRANSITIONS LIFESTYLE SYSTEM® WEIGHT MANAGEMENT PROGRAM WAIVER AND RELEASE OF LIABILITY FORM

INTRODUCTION

Approximately 60% of Americans are very overweight. These statistics continue to rise. A recent study compared various well-known weight loss programs and found that at the end of one year the average weight loss was approximately 10 pounds. In addition, the dropout rate in this study was approximately 35%. The purpose of the Transitions Lifestyle System Weight Management Program is to provide a lifestyle intervention of low glycemic index eating, exercise, nutritional supplementation, stress reduction/relaxation exercises, menu plan and a Daily Journal to empower participants to achieve their weight loss goals.

DESIGN

The program will be conducted over a 12-week period (12 sessions). Each week participants will attend a weekly educational meeting. During each meeting various topics will be covered such as understanding low glycemic index, the benefits of exercise, the benefits of stress reduction and the benefits of a healthy lifestyle. During Session One you will be given the Daily Journal, during which time all the components of the System will be explained, including low glycemic index food choices, meals plans, how to take the nutritional supplements, exercise choices, and how to fill in the Daily Journal to keep track of your food, exercise and lifestyle.

During Session One you will be weighed and measured with a tape measure. If you are a woman, measurements will be taken of your waist and hips. If you are a man, measurements will be taken of your chest and waist. Body fat % measurements will be recorded as well. Blood pressure and resting pulse will be recorded. Measurements will be repeated at Session 4, Session 8 and at Session 12.

Use of any dietary supplement may produce some rare adverse effects that may include: gas, loose stools and bloating. If you experience any of these effects please report them to your coordinator immediately.

EXCLUSION CRITERIA

If you are under the care of a physician for a medical condition or taking prescription drugs you may participate only with written permission from your physician.

CONFIDENTIALITY

The information gained from this program may be presented at scientific conferences or published in medical journals. Your name and likeness will not be used unless you authorize Market America to be allowed to use your information and you sign a release form.

VOLUNTARY PARTICIPATION

I am voluntarily participating in the Transitions Lifestyle System Weight Management Program. I reserve the right to refuse to participate in this program or withdraw at any time.

WAIVER AND RELEASE OF LIABILITY:

For and in consideration of the opportunity to participate in a Transitions Lifestyle System® Weight Management Program, and for other valuable consideration, the receipt and sufficiency of which is hereby acknowledged, for and on behalf of myself and my personal representatives, family, heirs, successors, assigns, and next of kin I _____ (Name of participant) do hereby fully and forever waive, release, discharge and covenant not to sue Market America, Inc., its successors, assigns, parents, subsidiaries, affiliates, owners, employees, representatives, officers, agents, contractors and directors (each considered one of the “Releasees” hereunder) from any and all liability, actions, causes of action, suits, proceedings, controversies, damages, judgments, executions, claims, and demands whatsoever, in law, equity or otherwise, that may arise and that may be caused or alleged to be caused, in whole or in part, by the negligence or intentional conduct of one or more of the Releasees or otherwise, including, but not limited to, any claim of personal injury, medical complications, allergic reactions, death, property damage or failure to achieve my desired health benefits. I intend this Waiver and Release of Liability to be effective whether or not any accident, loss, damage, injury or death results from the negligence or intentional misconduct of one or more of the Releasees.

I agree that if, despite this Waiver and Release of Liability, I, or anyone on my behalf including, but not limited to, my personal representatives, family, heirs, successors, assigns, and/or next of kin, makes a claim or claims against any or all of the Releasees, I will indemnify and hold the Releasees (or any one of them) harmless from any and all litigation expenses, attorney fees, claims, judgments, losses, liability, damages or costs which may be incurred by the Releasees (or any one of them) as a result of and/or in association with such claim or claims.

I have read and I voluntarily sign this Waiver and Release of Liability Agreement. I fully understand its terms, I understand that I have given up substantial rights by signing it and I have signed it freely and without any inducement or assurance of any nature and I intend it to be a complete and unconditional release of all liability to the greatest extent allowed by law. I agree that if any portion of this agreement is held to be invalid or unenforceable, the remainder shall continue in full force and effect to the maximum extent allowable by law. This Waiver and Release of Liability has no expiration date.

Signature: _____

Print Name: _____

Date: _____

Group Coordinator:

Print Name: _____

Signature: _____

Date: _____

**Medical Clearance and Physician's Consent to Participate
in Transitions Lifestyle System® Program (Including the use of Transitions™
Supplements)**

Patient Name _____

Name of Physician _____

Address _____

Phone _____

This form serves as a medical release for _____. I have assessed his/her physical condition and have determined that he/she may participate in the Transitions Lifestyle System® Weight Management Program. Any limitations or restrictions to consuming any of the Transitions supplements or on physical activity are listed below.

My patient, _____, is subject to the following **restrictions** in using 1 or all of the supplements in the Transitions Lifestyle System® or in physical activity/exercise:

In addition, under no circumstances should he or she do the following:

I have discussed the foregoing restrictions and limitations with my patient, _____, and, with these specific restrictions, he or she has my permission to participate in a Transitions Lifestyle System and pursue an exercise program.

Physicians Signature _____ Date _____