

Wall of Hope

Please Print

Name _____

Address _____

City, State, Zip _____

Phone (day) _____ (evening) _____

E-mail _____

_____ I would like to be a new participant in the Wall of Hope

_____ I would like to be included in the Wall of Hope with no changes

_____ I would like my picture and biographical information removed from the Wall of Hope

_____ I am already pictured but would like to submit new biographical information to be displayed with my picture.

Biographical Information (Will be included on Wall with your Photo)

Year of diagnosis: _____

Age at diagnosis: _____

Occupation: _____

Hometown: _____

Hobbies: _____

Quote: _____

Photo Consent (please sign and return)

I authorize The Breast Cancer Alliance of Greater Cincinnati to display my portrait and biographical information for the Wall of Hope. I understand the Wall of Hope will be displayed in public places at the discretion of The Breast Cancer Alliance of Greater Cincinnati. In addition, I understand that no preferential placement of any portrait and biographical material will be promised.

I, for myself, my heirs, executors, administrators, and assignees, do hereby give my consent and release any right, title, and/or interest of any kind to The Breast Cancer Alliance of Greater Cincinnati for my appearance in negatives, prints, slides, video, and reproduction. It is my understanding that The Breast Cancer Alliance of Greater Cincinnati use such material in which I appear in a legitimate manner, not to cause harm or undue embarrassment. I further understand that my name may or may not be associated with such negatives, prints, slides, video, and reproduction in which I appear.

I understand that at any time I wish to remove my portrait from the display, I may do so by notifying The Breast Cancer Alliance of Greater Cincinnati.

Signature: _____

Date: _____