

# AMAAYAHUASCA

## Retreat & Master Plant Dieta

### APPLICATION AND LIABILITY ACKNOWLEDGEMENT FORM

This document must be completed and signed prior to participation.

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#### 1. PERSONAL INFORMATION

**Full Name**

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**Date of Birth**

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**Nationality**

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**Passport Number**

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**Residential Address**

**Street**

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**Postal Code and City**

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**Country**

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**Phone Number**

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**Email Address**

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**Emergency Contact Person**

**Name**

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**Relationship**

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**Phone Number**

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## 2. HEALTH DISCLOSURE

Do you currently suffer from any physical illness

Yes  No

If yes, please describe:

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Do you currently suffer from any psychological or psychiatric condition

Yes  No

If yes, please describe:

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Are you currently taking any medication

Yes  No

If yes, please specify:

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I confirm that I have fully and truthfully disclosed all relevant physical, psychological and psychiatric conditions, including past diagnoses, treatments, medications and substance use.

I confirm

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## 3. EXPERIENCE

Have you previously participated in an Ayahuasca ceremony

Yes  No

Have you previously undertaken a Master Plant Dieta

Yes  No

If yes, please specify:

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What is your intention for participating in this Retreat or Master Plant Dieta:

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#### **4. ASSUMPTION OF RISK**

I understand and acknowledge that participation in an Ayahuasca retreat and Master Plant Dieta involves inherent and unpredictable physical, emotional and psychological processes.

These may include intense emotional experiences, physical discomfort, purging, temporary psychological distress, fatigue or unforeseen reactions.

I voluntarily choose to participate with full awareness of these risks.

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#### **5. RELEASE AND WAIVER OF LIABILITY**

To the fullest extent permitted by applicable law, I release and hold harmless Amaayahuasca, its founders, facilitators, shamans, employees and collaborators from claims, liabilities, damages or losses arising out of or related to my participation.

This does not apply in cases of proven gross negligence or intentional misconduct.

I understand that Amaayahuasca is not a medical facility and does not provide medical or psychiatric treatment.

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#### **6. MEDICAL EMERGENCY CONSENT**

In the event of a medical emergency, I authorize staff to seek appropriate medical assistance on my behalf.

I understand that any related medical costs are my sole responsibility.

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**Place**

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**Date**

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**Signature**

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**Full Name in Print**

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This document is legally binding upon signature.