



The Commonwealth of Massachusetts  
 Executive Office of Public Safety and  
 Security  
 Department of Fire Services



CHARLES D. BAKER  
 GOVERNOR  
 KARYN E. POLITO  
 LT. GOVERNOR  
 DANIEL BENNETT  
 SECRETARY

P.O. Box 1025 ~State Road  
 Stow, Massachusetts 01775  
 (978) 567~3100 Fax: (978) 567~3121

PETER J. OSTROSKEY  
 STATE FIRE MARSHAL

**Accident Waiver and Release from Liability (AWRL)**

By selecting the I AGREE check box below, I hereby acknowledge that certain training activities conducted by the Department of Fire Services, including but not limited to participation and/or observation of live burn exercises and all other activities relating to firefighting, fire protection, explosions, hazardous materials, environmental exposure, process safety and emergency response; present certain risks which are unavoidable.

I expressly acknowledge and understand that participation and/or observation of these activities at the Massachusetts Firefighting Training Academy are inherently dangerous. Although safety precautions are taken by the Department of Fire Services, the Massachusetts Firefighting Training Academy and its staff to protect myself, a certain degree of risk remains.

However, notwithstanding these risks and being fully informed, I, hereby assume these risks. Therefore, I agree to waive any claim of liability, now and forever, relating to or arising out of the above referenced activities which could be filed against the Department of Fire Services, Massachusetts Firefighting Academy, Commonwealth of Massachusetts or any of its departments, boards, commissions, trainers, agents, servants, employees or their consultants thereof, whether in their official or individual capacity. I hereby agree to indemnify and hold harmless all entities or persons mentioned in this paragraph from any and all liability or claims, whether in law or in equity, made by other individuals or entities as a result of my activities during this training.

I certify that I am physically fit and have not been advised otherwise by a qualified medical person.

I hereby certify that I have read this document and understand its content.

I AGREE

Printed name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_