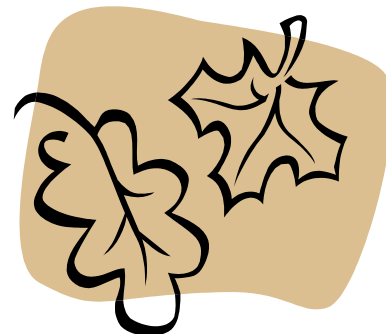


Adult Fall Retreat

Lake Chautauqua Lutheran Center
September 16-18, 2022



Please join us for this relaxing, rewarding, and rejuvenating program for adults. The retreat provides singles and couples the opportunity to spend time together in Christian fellowship and the beauty of autumn at LCLC.

Program offerings include:

- *Worship and Bible Studies
- *Special Presentations
- *Field trip opportunities
- *Crafts
- *Delicious food
- *Singing
- *Nature walks
- *Games, recreation, fun!
- *Comfortable hotel-style lodging
- *Archery and more...

WHEN: Friday at 7:00PM through breakfast on Sunday

WHERE: The Retreat Center (Our comfortable hotel-style accommodations.)

COST: Includes meals, lodging with linens, and program.

\$120 -individuals

\$224 -couples

\$25 of the registration fee is a non-refundable deposit.

Registration deadline is 9/9/22.

***Vaccination** against COVID-19 is strongly encouraged for attendance. Non-vaccinated participants are required to wear a mask and social distance when indoors and provide proof of a negative COVID-19 test result taken 1-3 days prior to 9/16/22.

✂ ----- ✂

LCLC Adult Fall Retreat Registration (By 9/9/22)

Names _____

Address _____
Street City State Zip

Phone _____ E-mail _____

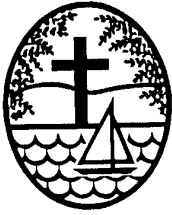
(Final Confirmation will occur via email)

Please make checks payable to LCLC or charge with your Visa, MC, AmEx, or Discover card:

Amount Enclosed _____ Check Number _____

Card Type _____ Card Number _____ 3 Digit Security Code _____ Exp. Date _____

Signature _____ Date _____



Lake Chautauqua Lutheran Center, Inc.

5013 Route 430
Bemus Point, NY 14712
716-386-4125
contact@lclcenter.org
www.lclcenter.org

LCLC Adult Fall Retreat Consent for Medical Treatment Form

I, the undersigned, hereby authorize a representative of Lake Chautauqua Lutheran Center to seek emergency medical treatment, surgery or dental care to be given to myself as considered advisable or necessary in the judgment of an emergency medical professional or attending physician.

Names: _____

Signature Physician Phone

Date Insurance Company Policy #

Insurance Company Address City State Zip

Home Phone Work Phone Allergies, Conditions or Medications of which we should be aware?

Medical Conditions continued.... Secondary Emergency Contact: Name Phone Relationship