Membership Application

First Name_____ Last Name_____ MI_____

Preferred Name_____ Date of Birth____/____/____ M/F (circle) Weight_____ Height_____

Mailing Address_____ City_____ State_____ Zip_____

Home Phone_____-_____-_____ Work Phone_____-_____-_____ ext._____

Cell Phone_____-_____-_____ E-mail_____

Occupation_____ Employer_____

Emergency Contact Name_____ Relationship_____

Emergency Contact Number_____-_____-_____ Physician (name)_____

How did you hear about the SCCH Fitness Center? (check one) ___Newspaper ___Radio___Other

Friend/Relative (name)_____

Payment Type: Cash/Check Credit Card Payroll Deduction*

Cash $_____ Check #_____ Check $_____

*Payroll deduction is available for SCCH employees only, see consent form.

MEMBERSHIP AGREEMENT

I understand that by becoming a member of the Sullivan County Community Hospital Fitness Center that I will have the right to enjoy all of the facility and will be subject to all of the rules of the SCCH Fitness Center. I understand that a violation of these rules may result in termination of my membership.

All memberships are non-refundable and non-transferable.

I understand that a fitness evaluation and orientation is made available to me on a voluntary basis. I further understand that I may suffer adverse consequences from the exercise test or any exercise activity or program at the Sullivan County Community Hospital Fitness Center including abnormal blood pressure, fainting, disorder of heartbeat, and in rare instances heart attack or death. I agree that upon answering the Health history for questionnaire, that my doctor may be contacted to release me for physical activity at the Sullivan County Community Hospital Fitness Center.

I agree to indemnify and hold harmless Sullivan County Community Hospital Fitness Center and their agents and employees from any liability for any claims, demands, costs or judgements against it or them arising from my membership and activities at the Sullivan County Community Hospital Fitness Center.

_____ _____

Member Signature Date

_____ _____

Fitness Center Staff Signature Date

Health History Form

Please circle yes or no to the following questions:

Y/N Do you know of a heart murmur?

Y/N Have you been diagnosed by a physician with high blood pressure?

Y/N Have you been diagnosed by a physician with high cholesterol?

Y/N Are you diabetic? _____insulin dependent _____non—insulin dependent

Y/N Do you smoke cigarettes or cigars?

Y/N Are you over 65 years of age?

Membership 2

Y/N Are you currently pregnant?

_____ I will notify the fitness center if I do become pregnant

Member Signature

Y/N Do you experience chest pain?

Y/N Do you experience shortness of breath?

Y/N Do you experience dizziness or fainting?

Y/N Do you experience swelling of the ankles?

Y/N Do you experience pain in the legs that causes you to stop walking?

Membership 1

Please list any medications you are currently taking:

_____ _____

_____ _____

_____ _____

_____ _____

Please give an explanation and the dates of occurrences:

Have you had a back injury_____

Have you had broken bones_____

Have you been diagnosed with Arthritis_____

Have you had any joint problems_____

Please circle your special interests:

A. Aerobics
B. Fitness Assessments
C. Cardiovascular exercise
D. Free Weights
E. Program Design
F. Strength Training
G. Track
H. Other: (Explain)_____

Please rate your top three fitness goals with 1 being the most important:

_____Increase cardiovascular endurance

_____Increase Strength

_____Decrease weight or inches

_____Increase weight or inches

_____Increase flexibility and balance

_____Stress Relief

_____ Begin a consistent exercise program

_____Other (Explain)_____