MEMBERSHIP APPLICATION

Name: ____ Social Security #: ________________________________

Date of Birth: ____________ Gender: M / F Email Address: ____

Home Address: ____________________________________ City:_______________ State:____ Zip Code: ___________

Home Phone: ____________________ Work Phone: _____________________Cell Phone: _________________________

Employer Name or School Name (if applicable): ____

Emergency Contact: ____________________________Relationship: _____________Phone:_________________________

PAYMENT INFORMATION:

( ) Automatic Billing by Checking Account ** Must provide a voided check**

Bank Name: __________________ Routing Number: ____________________ Account Number: _________________

( ) Automatic Billing by Credit/Debit Card

Credit/Debit Card Type: _______ Credit Card Number: ___________________________________ Exp. Date: ______

( ) Payroll Deduction: (ALH Employees ONLY) Employee badge #: _________________ (Ask front desk for form)

I, ___________________________________, hereby authorize ALH Wellness Center to deduct recurring dues from the above account on the first of every month. I understand that a $30.00 service charge will be incurred on my account for returned electron funds transfer, returned checks, and/or declined credit card transactions. I understand that, should the account come into arrears, I will be responsible for any charges related to bringing the account up to date. This will include all service charges, collection agency fees, etc…

****I understand that in order to cancel my membership with ALHWC I am REQUIRED to submit a 30-day written notice. The cancellation will be effective at the end of the following month, unless submitted by the 10th. Cancellation will not be prorated.****
****I understand membership dues and assessment fees are non-refundable and/or non-transferable.****

___________________________________ ______________________ ________________
Applicant's Signature Date Emp. # (If Applicable)

____ ________________
Signature of Parent or Legal Guardian If Member is Under the Age of 19 Date

FOR OFFICE USE ONLY:

Member Type: ____________________ Company/School Name:___________________________

Monthly Membership Fee: ____________ Member Responsible for Account:_____________________________________

Full Amount Paid Today: _____________ Amount for: FA_________ Processing Fee________ Prorated Amt:______________

Payment Type: Cash_________CC________Check #_____________ On Account: _________ ______________

Today's Date:_______________ Date to Begin Automatic Billing_____________________ Employee's Initials:__________

Membership ID #: _____________

Name	Height	Weight	Age/Gender

Yes	No	Has a doctor ever diagnosed you with a heart condition? (If yes, when and what was the diagnosis?)

Yes	No	Do you have breathing problems? (COPD, chronic bronchitis, symptomatic asthma?)
Yes	No	Do you have a kidney, liver, or thyroid disorder?
If yes to either of the above, please explain:		

Yes	No	Do you have Diabetes? If yes : Type 1 Type 2 How long?
Yes	No	Have you ever had a stroke or TIA (Transient Ischemic Attack)? When?
If yes to either of the above, please explain:		

Yes	No	Do you have pain in your legs when walking moderate distances?
Yes	No	Do you have chest pain brought on by physical activity?
Yes	No	Have you had any problems with dizziness or fainting?
Yes	No	Do your ankles swell (edema)?
Yes	No	Do you have bone or joint problems that could be aggravated by physical activity?
Yes	No	Do you get short of breath with mild exertion?
If yes to any of the above, please give specifics:		

Yes	No	Has a doctor ever recommended medication for your blood pressure or a heart condition?
Yes	No	Has your total cholesterol been measured at greater than 200 mg/dl?
Yes	No	Has your doctor ever said that you blood sugar is too high? (Fasting >100 mg/dl)
Yes	No	Do you have a family history of heart disease in a relative younger than 55? *Relation:*
Yes	No	Do you use tobacco products? *Which and how long:*
Yes	No	Are you physically inactive on most days?
Yes	No	Are you pregnant or recently pregnant?
Yes	No	Are you aware of any other physical reason that would prohibit you from exercising without medical supervision?
If yes to any of the above, please give specifics:		

Please list any current medications (current or over the counter):

Primary Care Physician Information (please print)

Name: Location: Phone:

Office Use Only:

Risk Stratification: Low Moderate High

Staff Signature: _______________

LIABILITY RELEASE/ASSUMPTION OF RISK

Any member, guest or other person who in any manner makes use of or accepts the use of any apparatus, appliance, facility, privilege, or service of the Wellness Centers owned and operated by Athens-Limestone Hospital, or who engages in any contest, game, function, exercise competition or other competition or activity operated, organized, arranged or sponsored by the Wellness Center, on or off the Wellness Center's premises, shall do so at his/her own risk, and shall hold owners and their principals, directors, officers, employees, representatives, agents, landlord and land owners harmless from any and all loss, cost, claim, injury, damage and liability, sustained and/or resulting from any act of any and all principal, director, officer, employee representative or agent of owner. I, the undersigned, hereby expressly and affirmatively state that I wish to participate in physical activity at Athens-Limestone Hospital Wellness Center. I do recognize that my participation in this activity involves risk of injury, including serious disabling injuries that may arise due to my participation in this activity. However, knowing the materials risk and appreciating, knowing, and reasonably anticipating that other injuries and even death are a possibility. I hereby expressly assume all of the delineated risks of injury, and even the risk of death, which could occur by reason of my participation.

I, the undersigned, understand, have read and have had any questions answered in regards to the disclaimer of Owners Liability policy and agree to the above.

I understand that I am exercising/participating without the release of a physician and assume all responsibility personally. ______________ (Initial).

Print Name: ____

Signature: ____

Parent if under age 19: ____

Witness: ___________________

Date: _____________________