

Myrtue Medical Center
McDowell Fitness Center
Membership Agreement

Name: _____ Application Date: _____ Membership #: _____

Address: _____ City, State, Zip: _____

Phone (home): _____ (work): _____ Physician: _____ Phone: _____

Notify in case of emergency: _____ Phone: _____ Email _____

Names of family members included in membership, if any:

_____	Age _____
_____	Age _____
_____	Age _____
_____	Age _____
_____	Age _____

This is your agreement to become a member of the Myrtue Medical Center McDowell Fitness Center. As used in this agreement, the words "you" and "your" mean the MEMBER signing this contract, and the words "Fitness Center", "us", and "our" mean the Myrtue Medical Center McDowell Fitness Center. Upon acceptance, you will be entitled to use the Fitness Center facilities and equipment subject to this agreement. You understand that your membership is not an equity or ownership investment in the Fitness Center. PLEASE READ THIS AGREEMENT CAREFULLY. If you agree to be bound by it, please sign it.

1. Membership Requirements:

All applicants for membership to the Fitness Center must complete and satisfy all requirement of active membership before participation in any program may begin. To be completed: Membership Agreement, Health Risk Profile, Basic Health Screen, Safety/Equipment Orientation and payment of membership fees.

2. Membership Types:

- Family Husband, wife, and dependant children age 12-21. Parental supervision required for children 12-13 years of age. Children under 12 are not allowed in the fitness area.
- Single Individual 14 years of age or older. Parental consent required for individuals under 18 years of age.

3. Membership Term and Payment Schedule:

- Annual: One calendar year beginning with date of application completion. Member is responsible for payment of total amount of yearly fee.

PAYMENT OPTIONS

Family

- (1) Yearly payment of \$290.00
- (2) Semi-annual payments of \$155.00
- (4) Quarterly payments of \$80.00
- Payroll Deduct (\$5.57 per pay period)

Single

- (1) Yearly payment of \$184.00
- (2) Semi-annual payments of \$100.00
- (4) Quarterly payments of \$52.00
- Payroll Deduct (\$3.53 per pay period)

- Also available: If you are an employee, please ask about the PRD for 6 months

- Seasonal: Four consecutive months beginning with date of application completion.

Family

- (1) Payment of \$155.00

Single

- (1) Payment of \$95.00

- One Month: One month beginning with date of application completion.

- (1) Payment of \$27.00

- Punch Card: 12 visits to the Fitness Center for card user. Expires one year from date of purchase.

- (1) Payment of \$37.00

- Daily Pass: 1 day pass to the Fitness Center.

- (1) Payment of \$5.00

You will be billed for Annual membership fees only as per your agreement terms. All other membership types must be paid in full. An "expiration" notice will be sent to all members at the end of their membership term.

Discounts: Discounts are available to Myrtue Medical Center employees, Occupation Health Outreach employees and Senior Citizens on Annual and Seasonal memberships only.

Freeze Option: Members can "freeze" their annual or seasonal memberships if ill or out of town for 2 weeks or more during their membership term.

4. **Membership Privileges:**
 Current Annual Memberships will be allowed (1) Free Guest Pass per month. Fitness Center member must accompany Guest while in the facility, and both Guest and Member are required to sign a "Guest Pass Waiver and Release" form before participation may begin. Current Fitness Center membership includes aerobic classes and access to all Fitness Center facilities and equipment.

4. **Facilities and Equipment:**
 The Fitness Center retains the right to determine the days and hours during which the Fitness Center facilities will be available to members and the equipment and services that will be offered. You understand that the Fitness Center may change these.

5. **Refunds:**
 No Refunds will be given on Seasonal memberships, Punch Cards, One Month memberships or Daily Passes. Refunds will be given for Annual memberships for the following reasons only: (1) Medical – a written statement from physician for individual to stop exercise, and (2) Change of Residence – further than a 50 mile radius from the Fitness Center. Refund will not be more than one half of membership remaining rounded to the nearest quarter.

6. **Termination of Membership:**
 Fitness Center reserves the right to terminate membership due to non-payment of membership fees, or failure to comply with the Rules and Regulations set forth by the Fitness Center. If membership is terminated for non-payment, the remaining balance must be paid in full prior to future renewal of membership.

7. **Agreement and Release of Liability:**
 I do hereby waive, release and forever discharge the Fitness Center, its officers, and employees from any and all responsibilities or liability for injuries or damages resulting from my participation in any activities or use of equipment in the above-mentioned facility. _____ (PLEASE INITIAL)

I understand and am aware that strength, flexibility and aerobic exercise, including the use of equipment, is a potentially hazardous activity. I also understand that fitness activities involve a risk of injury or illness and that I am voluntarily participating in these activities and using equipment with knowledge of the dangers involved. I hereby agree to expressly assume and accept any and all risks of injury or illness. _____ (PLEASE INITIAL)

I acknowledge that I have either had a physical examination and have been given my physician's permission to participate, or that I have decided to participate in the activities or use of equipment without the approval of my physician and do hereby assume all responsibility for my participation in activities or use of equipment at the Fitness Center. _____ (PLEASE INITIAL)

I HAVE READ AND UNDERSTAND THE TERMS OF THIS MEMBERSHIP AGREEMENT.

 Member Signature

 Parent or Guardian if member is under 18 years

 Date

Our child(ren) may participate as a member of the McDowell Fitness Center.

PAYMENT RECORD

Membership Type:

- | | |
|---|--|
| <input type="checkbox"/> Family Annual | <input type="checkbox"/> Family Seasonal |
| <input type="checkbox"/> (1) Annual Payment | <input type="checkbox"/> Single Seasonal |
| <input type="checkbox"/> (2) Semi-annual Payments | <input type="checkbox"/> One Month |
| <input type="checkbox"/> (4) Quarterly Payments | <input type="checkbox"/> Punch Card |
| <input type="checkbox"/> Single Annual | |
| <input type="checkbox"/> (1) Annual Payment | |
| <input type="checkbox"/> (2) Semi-annual Payments | |
| <input type="checkbox"/> (4) Quarterly Payments | |

<u>Payment Date</u>	<u>Amount</u>
Jan: _____	_____
Feb: _____	_____
Mar: _____	_____
Apr: _____	_____
May: _____	_____
Jun: _____	_____

<u>Payment Date</u>	<u>Amount</u>
Jul: _____	_____
Aug: _____	_____
Sep: _____	_____
Oct: _____	_____
Nov: _____	_____
Dec: _____	_____

HEALTH RISK PROFILE

Name: _____ Date: _____ Membership #: _____

1. Are you presently taking any medications? _____ YES _____ NO
Please list ALL MEDICATIONS and what conditions they are taken for:

2. Date of your last physical exam: _____ 3. Your AGE: _____

HAVE YOU EVER HAD, OR HAVE YOU NOW, ANY OF THE CONDITIONS LISTED BELOW?

	YES	NO
4. A history of heart problems?	_____	_____
5. A history of high blood pressure (above 140/90)?	_____	_____
6. A history of lung/respiratory problems?	_____	_____
7. Diabetes? or High blood sugar?	_____	_____
8. Now or have been pregnant within past 3 months?	_____	_____
9. Difficulty with physical exercise?	_____	_____
10. A chronic illness?	_____	_____
11. Muscle, joint, or back disorder that could be aggravated by physical activity?	_____	_____
12. Recent surgery (within past 3 months)? If "yes", what type? _____	_____	_____
13. Advice from your physician NOT to exercise?	_____	_____
14. Do you smoke? If "yes", how many per day? _____	_____	_____
15. Are you more than 20 pounds overweight?	_____	_____
16. Do you have high blood cholesterol (above 240 mg/dl)?	_____	_____
17. Has anyone in your family (parents, grandparents, or brothers/sisters had a history of heart problems? Who? And age of relative(s) when diagnosed. _____	_____	_____

Explanation to any "YES" answer to the above questions and when the condition occurred. _____

BASIC HEALTH SCREEN

Date	Resting Heart Rate	Blood Pressure	Height	Weight
_____	_____	_____/____	_____	_____

TRAINING HEART RATE

	Low/Moderate 220	Moderate/High 220
Your age:	- _____	- _____
Maximal Heart Rate (MHR):	= _____	= _____
Exercise Intensity Level:	X .60	X_ .85
Heart Rate Beats Per Min (bpm):	= _____	= _____
	÷ 10	÷ 10
Heart rate per 6 second count:	= _____	= _____

GOALS

