Peoplefit℠
Supportive Fitness for Healthy Living

Membership Agreement (month to month)

(Please Print & See Back)

Date _____ **Birth Date** _____

Name_____ **Nickname** _____

Address_____

City_____**State**_____**Zip**_____

Phone (Home)_____(Cell)_____(Work)_____

Email_____

Company_____**City**_____

Emergency Contact_____**Relationship**_____**Phone**_____

Do you have any friends or family who would like to receive a complimentary membership?

	Name	**Address**	**Phone**
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Principal Interests *(please check all that apply)*

___Strength Training ___Cardiovascular ___Personal Training ___Nutrition

___Stretching ___Stress Reduction ___Weight Loss ___Other

How did you hear about us? ***(please check all that apply)***

___Yellow Pages ___Value Pack ___Town Paper ___Shoppers ___Postcard

___Friend ___Flyer/Brochure ___Comm. Event ___Street Sign ___Dr./PT Office

___Member: Name _____ ___Door Hanger ___Internet ___Other

OFFICE USE ONLY

Membership Type: Individual_____Family_____

Monthly Dues_____**Upon Joining Paid**: Dues_____Enrollment_____Trng_____Total _____

Payment Details_____

Date Paid_____Start Date_____First Appt_____

Transaction Completed By_____Promo Code_____

Medical Risks

I agree to participate in programs offered by Peoplefit LLC ("Peoplefit") upon understanding that:

- I acknowledge that I have been advised of medical risks that may result from participation and I have consulted my personal physician and am physically capable of participation without injury.
- I recognize the risk of injury or death in any exercise program and am participating upon the express agreement and understanding that I am hereby assuming, on behalf of myself, my heirs , successors or assigns , all risk or responsibility for any illnesses or injuries that I might sustain, including but not limited to the risk of death, as a result of my participation in the programs offered by Peoplefit Health and Fitness Center ("Peoplefit") and/or of my presence on the premises.

Cancellations & Freezes

I may cancel my membership at any time and for any reason. If the cancellation occurs within 30 days of joining, I will receive a full prorated refund of membership dues (refund does not apply to enrollment fee or to renewals and is only applicable when you join for the first time).

CONSUMER'S RIGHT TO CANCELLATION: YOU MAY CANCEL THIS AGREEMENT WITHOUT ANY PENALTY OR FURTHER OBLIGATION BY CAUSING A WRITTEN NOTICE OF YOUR CANCELLATION TO BE DELIVERED IN PERSON OR POSTMARKED BY CERTIFITED OR REGISTERED UNITED STATES MAIL WITHIN THREE (3) BUSINESS DAYS OF THE DATE OF THIS AGREEMENT OR THE DATE OF YOUR RECEIPT TO THE ADDRESS SPECIFIED IN THIS AGREEMENT.

I may put my membership on freeze if:

- I plan to be away for a month or more and can provide Peoplefit with verification that I will be away. There is a limit of one "out of town" freeze per calendar year for a maximum of 60 days.
- I have a medical condition that is verified in writing by a physician. A fee-for-service physical therapy evaluation may be required upon return from freeze.

CANCELLATIONS AND FREEZES MUST BE PUT IN WRITING AND DELIVERED IN PERSON OR POSTMARKED BY CERTIFIED OR REGISTERED UNITED STATES MAIL BY THE 15TH OF THE MONTH PRECEEDING THE CANCELLATION OR FREEZE TO THE ADDRESS SPECIFIED IN THIS AGREEMENT. If you deliver the letter in person, it is your responsibility to request a signed copy of the letter verifying receipt.

Applicant Signature_____ Date_____

Specific Center Guidelines

Center rules are not limited to these and are subject to change. These rules are enforced for your safety and convenience, as well as the safety and convenience of others. We appreciate your full cooperation.

- There is a 30 minute limitation on all cardiovascular equipment if members are waiting to use the equipment.
- There are times throughout the year that the center is closed or has reduced hours on weekends and/or holidays.
- I agree to adhere to Peoplefit's safety protocols, which may be updated over time, each time I visit the facility.
- We respectfully request that fitness shoes are carried into the facility.

Applicant Signature_____ Date_____

Monthly Payment Agreement: Payments are due ON or BEFORE the first of the month IN WHICH SERVICES ARE RENDERED. **I authorize Peoplefit to automatically withdraw monthly payments from my credit card/bank account.**

- If payment is late for any reason, a $10.00 surcharge will be charged without further notice to you.
- If monthly dues payments are delinquent for 2 consecutive months your membership will be suspended until payment is made.
- The undersigned agrees to make membership payments at the agreed time regardless of the amount that she/he uses the center.

YOU ARE COMMITTED TO MONTHLY PAYMENTS. THIS AGREEMENT WILL CONTINUE ON A MONTHLY BASIS UNLESS PEOPLEFIT RECEIVES A WRITTEN NOTICE BY CERTIFIED MAIL. NOTIFICATION RECEIVED BY THE 15TH OF THE MONTH WILL RESULT IN A CANCELLATION DATE OF THE END OF THAT MONTH. NOTIFICATION RECEIVED AFTER THE 15TH OF THE MONTH WILL RESULT IN A CANCELLATION DATE OF THE END OF THE FOLLOWING MONTH.

Applicant Signature _____ Date_____

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Health History Questionnaire

Today's Date: _____

Name: _____ Birth Date: _____/_____/_____

Sex: _____ Age: _____ Cell Phone: _____

Home Phone: _____ Work Phone: _____

Height: _____ft _____ in Weight: _____ lb Email: _____

Physician's Name/Address: _____

Physician's Phone Number: _____ Date of Last Physical Exam: _____

In Case of Emergency:

Contact Person: _____ Relationship: _____
Phone: (home) _____ (cell) _____ (work) _____

Have you ever had any of the following? (Please check)

____Heart Attack
____Heart Surgery
____Cardiac Catheterization
____Coronary Angioplasty
____Heart Failure
____Heart Transplantation
____Congenital Heart Disease
____Coronary Heart Disease
____Rheumatic Heart Disease
____Angina
____Heart Murmurs
____Heart Valve Problems
____Stroke
____Diabetes (high blood sugar)
____Hypertension (high blood pressure)
____Epilepsy
____Cancer
____Disease of the kidney, liver or thyroid
____A Pacemaker/Implantable Cardiac Defribillator/Rhythm Disturbance
____Asthma
____Emphysema

Please explain: _____

Are you taking any prescription drugs? If yes, which ones and for what reason?
_____

Are you under a doctor's care? If so, please explain.
_____

Do you have any medical conditions for which a physician has recommended some restrictions on activity? (Please circle) Yes No

If yes, please explain: _____

Do you currently exercise? (Please circle) Yes No
Do you currently smoke? (Please circle) Yes No

Have you ever experienced any of the following (Please check)

	At Rest	During Exercise (Including at work, Climbing stairs & walking)
Pain or discomfort in the chest	_____	_____
Inappropriate shortness of breath	_____	_____
Dizziness, fainting, blackouts	_____	_____
Claudication (poor circulation in legs due to blood clot)	_____	_____

Females only ☺

Are you pregnant? _____Yes ____No If yes, what is your expected due date?_____

Have you had a recent pregnancy? (Last 3 months?) _____Yes _____No

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Has anyone in your immediate family had any of the following before the age of 55?

	Relative:	Age Diagnosed:
Heart Attack	_____	_____
Angina Pectoris (Chest pain)	_____	_____
High Blood lipids (High Cholesterol & Triglycerides)	_____	_____
Stroke	_____	_____
Hypertension (High blood pressure)	_____	_____
Diabetes	_____	_____

Have you ever had any of the following problems concerning your joints muscles and/or supportive tissues? If yes, please indicate the joint/muscle involved

Hernia or Rupture	YES:_____
Arthritis/Bursitis	YES:_____
Back Injury/Pain	YES:_____
Bone Fracture	YES:_____
Joint Dislocation	YES:_____
Tendon, Ligament, Cartilage	YES:_____
Orthopedic Surgery (Bone, muscle or joint related surgery)	YES:_____
Other Surgery	YES:_____
Osteoporosis	YES:_____
Other/Miscellaneous	YES:_____

Have you had your cholesterol measured within the past year? ____Yes ____No

If yes, what was the reading? Total_____ HDL_____ LDL_____

Is there anything else that you would like to tell us about your health/nutrition/family history?

_____

_____

Please sign below acknowledging that the above information is true to the best of your knowledge.

Signature: _____ Date:_____

Thank you for taking the time to fill out this form!

Independent Program Participation Release and Waiver

In consideration of the undersigned being on premise of voluntarily participating in the independent program at **Peoplefit Health and Fitness Center**, the undersigned, individually and on behalf of the undersigned's heirs, representatives and next of kin, agrees to:

1. release, waive and discharge, and to indemnify and hold harmless, Peoplefit and its employees and affiliates from all loss, expense and liability for injury, death or damages to the person or property of the undersigned while using Peoplefit's facilities; and

2. assume full responsibility for risk of injury, death or damages to the person or property of the undersigned, while using Peoplefit's facilities.

I understand the program is not a physical therapy program, nor a substitute for medical treatment. I do represent and warrant that I have been advised to seek consultation from my doctor about whether I can safely participate in this program and whether there are precautions or limitations to my participation.

The Facility (Peoplefit) reserves the right to limit participation of individuals when criteria are not met or the safety of participants or staff is compromised.

The undersigned acknowledges that no oral or written statements or agreements contrary to this document have been made to the undersigned and that this document supersedes any and all prior statements and agreements with Peoplefit. The document may only be changed in writing executed by Peoplefit.

The agreements in this document shall be continuing and shall not terminate without the prior written consent of Peoplefit.

The undersigned has read, understands and voluntarily signs this document.

Date: _____ Signature: _____

Print Name: _____

The American College of Sports Medicine recommends obtaining a Doctor's Clearance prior to beginning an exercise program if you have more than two risk factors. If you do have two or more risk factors, do you authorize Peoplefit to obtain a clearance from your physician and renew it as deemed appropriate by your physician?

Yes **No**

Date_____

Print Name_____ Signature_____

SHOULD YOU CHOOSE NOT TO OBTAIN DR. CLEARANCE, YOU MUST SIGN THE WAIVER BELOW.

MD CLEARANCE WAIVER

I waive the recommendation to obtain a clearance to exercise from my doctor and accept full responsibility for my use of any and all apparatus, appliances, facility privilege or service whatsoever, owned and operated by Peoplefit. I agree to exercise at my own risk and shall hold this Center, its shareholders, directors, managers, members, officers, employees, representatives, and agents harmless from any or all loss, claim, injury, damage, or liability sustained or incurred by me resulting therefrom.

Date_____

Print Name_____ Signature_____