



Membership Agreement (year)

(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	Email
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 _____ PIF12: _____ PIF13: _____ EFT: _____

Monthly Dues _____ **Upon Joining Paid:** Dues _____ Enrollment _____ Trng _____ Total _____

Payment Details _____

Date Paid _____ Start Date _____ Exp Date (PIF only) _____ 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 program offered by Peoplefit Health and Fitness Center (“Peoplefit”) and/or as a result of my presence on the premises.

Cancellations & Freezes

I understand that I am making a commitment to twelve (12) total months of paid membership which may be paid in monthly installments or in full. Exceptions to my one-year commitment are listed below.

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 CERTIFIED 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 also may cancel my membership within 30 days of joining for any reason and 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).

ADDITIONAL RIGHTS TO CANCELLATION

You or your estate may also cancel this agreement for any of the following reasons:

- ◆ If upon a doctor’s order, you cannot physically or medically receive the services because of significant physical or mental disability for a period in excess of three months.
- ◆ In case of your death.
- ◆ If the health center services to be provided under this agreement are not available because the seller fails to open a planned health center or location, permanently discontinues operation of a health center or location, or substantially changes the operation of a health center or location.
- ◆ If you move either your residence or your place of employment more than twenty five (25) miles from any health center operated by the seller or a substantially similar health center which will accept the seller’s obligation under the 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 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 PRECEDING THE CANCELLATION OR FREEZE TO THE ADDRESS SPECIFIED IN THIS AGREEMENT.

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 A ONE YEAR MEMBERSHIP WITH 12 MONTHLY PAYMENTS AS SPECIFIED ON THE FRONT OF THIS AGREEMENT. THIS AGREEMENT WILL CONTINUE ON A MONTHLY BASIS AFTER THE FIRST 12 PAYMENTS 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 _____



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)

- | | |
|---|--|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Heart Valve Problems |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cardiac Catheterization | <input type="checkbox"/> Diabetes (high blood sugar) |
| <input type="checkbox"/> Coronary Angioplasty | <input type="checkbox"/> Hypertension (high blood pressure) |
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Heart Transplantation | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Disease of the kidney, liver or thyroid |
| <input type="checkbox"/> Coronary Heart Disease | <input type="checkbox"/> A Pacemaker/Implantable Cardiac |
| <input type="checkbox"/> Rheumatic Heart Disease | <input type="checkbox"/> Defibrillator/Rhythm Disturbance |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart Murmurs | <input type="checkbox"/> 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

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 _____