3726 Houma Boulevard
Metairie, LA 70006
(504) 849-6868

DATE: ____/____/____

NEW MEMBERSHIP AGREEMENT NO._____
MEMBERSHIP TYPE: [ ] GENERAL [ ] 65 PLUS [ ] DISEASE MANAGEMENT [ ] CORPORATE

_____
Last Name First Name Middle Initial Marital Status: Married, Single, Divorced, Widowed

_____
Present Mailing Address City State Zip Code

(___)_____(___)_____/_____/_____
Home Phone Other Phone Birthdate E-Mail Address

_____(___)_____
Current Employer Occupation In case of emergency, notify Phone #

_____
How did you hear about us?

***********Persons to be Issued Membership Cards**********

1._____	2._____	3._____	4._____
ID _____	ID _____	ID _____	ID_____
DOB ____/____/____	DOB ____/____/____	DOB ____/____/____	DOB ____/____/____

Membership Privileges, Notices, Disclosures & Agreement

Membership Agreement, Waiver & Release

In consideration of gaining membership and being allowed to participate in the activities and programs of the East Jefferson General Hospital Wellness Center (the "Facility") and to use its facilities, equipment, and machinery, in addition to the payment of any fee or charge, I do hereby agree to the following:

1. I covenant not to sue and hereby forever release, waive and discharge the Wellness Center of East Jefferson General Hospital, its owners, directors, officers, operators, employees, a agents, representatives, members and guests (hereinafter referred to as "Releasee") from any and all responsibility or liability for bodily injury, death or property damage resulting from my participation in any activity or my use of any equipment or machinery while I am in, upon, or about the premises of the Facility, including, without limitation, the locker room, restroom, parking area and sidewalk area. I further hereby agree to indemnify, save and hold harmless each and every Releasee from any loss, liability, damage or cost he/she may incur due to my presence or participation in any activity or my use of any equipment or machinery while I am in, upon, or about the Facility or participating in any program affiliated with the Facility. **(Please initial _____, _____, _____, _____)**

2. This waiver and release of liability includes, without limitation, all bodily injuries and property damage which may occur regardless of Releasee's negligence, as a result of: my use of any amenity or equipment in the Facility and my participation in any activity, class, program, personal training or instruction; the malfunctioning of any equipment; the instruction, training, supervision, or dietary recommendations made to me by any Releasee; and my slipping and/or falling while I am in, upon, or about the Facility, including, without limitation, the locker room, restroom, parking areas and adjacent sidewalks. **(Please initial _____, _____, _____, _____)**

3. I understand and am aware that strength, flexibility, and various activities and exercise, including the use of equipment, are potentially hazardous. I also understand that fitness activities involve a risk of injury and even death and that I am voluntarily participating in these activities and will use the equipment and machinery properly and with knowledge of the dangers involved. I hereby agree to expressly assume and accept any and all risks of bodily injury, death or property damage that may result. **(Please initial _____, _____, _____, _____)**

4. I do hereby further declare myself to be physically sound and suffering from no condition, impairment, disease, infirmity, or other illness that would prevent my participation in any of the activities and programs of the Facility or use of its equipment or machinery. I do hereby acknowledge that I have been informed and am aware of the recommendation to have a physician's approval for my participation in an exercise/fitness activity or in the use of exercise equipment and machinery. I also acknowledge that it has been recommended to me that I have a yearly or more frequent physical examination and consultation with my physician as to physical activity, exercise and use of exercise and training equipment so that I might have his/her recommendations concerning these fitness activities and equipment use. 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 activity and/or use the Facility's equipment and machinery without the approval of my physician and do hereby assume all risk and responsibility for said participation and use of equipment and machinery in these activities. **(Please initial _____, _____, _____, _____)**

Member: _____ **Member:** _____
Member: _____ **Member:** _____
Witness to Signature: _____

Request for Pre-Authorization

I/we hereby request the privilege of making payments to East Jefferson General Hospital Wellness Center, 3726 Houma, Blvd, Metairie, LA 70006, under the Wellness Center's Preauthorization Payment Plan and hereby request the Wellness Center to draw items (checks, electronic fund transfers, Visa, MasterCard, Amex, or Discover) for the purposes of making said payments on the account of:

_____ (Name as shown on account)

Credit Card Account _____Expiration Date _____/_____

Checking Account (Bank Name)_____

[ ] Checking [ ] Savings Acct No. _____Routing _____

On the 15th day of the month, I authorize **EAST JEFFERSON GENERAL HOSPITAL WELLNESS CENTER** to initiate electronic entries into my checking account and have agreed to the terms listed on the authorization. I may revoke my authorization with a 30-day written notice to the Wellness Center at the address listed above.

Initial Payment Amount: **$**_____ (if payment changes we will notify you at least 10 days before the regularly scheduled payment date).

Regular Payment Date: **15th day of the Month**. Regular Monthly Payment: **$**_____

Subject to the following conditions:

1. The items shall be drawn on or about the 15th day of every month. The transaction on your bank or credit card will constitute receipt for payment.
2. A service charge of $25 will be assessed to all insufficient drafts, checks, electronic funds transfers, or charge cards.
3. A 30-day written notice to the Wellness Center address above **is required to stop payment.**
4. Failure or inability to regularly attend & utilize facilities does not relieve member of financial responsibilities nor entitles member to a refund, extension or member transfer regardless of the circumstances. THERE WILL BE NO CASH REFUNDS! Also, no transfers to another member will be allowed, unless there is written proof of a medical excuse or if the member calls before the time missed.

Customer's Signature: _____

A Voided Blank Check Must be Attached If Authorizing Transfer from a Checking Account

HEALTH HISTORY QUESTIONNAIRE

Member's Name (Please Print): _____

Telephone Number: _____

Height: _____ Weight: _____ Gender: _____

Regular physical activity is safe for most people. However, some individuals should check with their physician before they start an exercise program. To help us determine whether you should consult with your physician before starting to exercise with East Jefferson General Hospital Wellness Center, please read the following questions carefully and answer each one honestly. All information will be kept confidential. Please check YES or NO.

Yes	**No**	
____	____	1. Do you have a heart condition?
____	____	2. Have you ever experienced a stroke?
____	____	3. Do you have epilepsy?
____	____	4. Are you pregnant?
____	____	5. Do you have diabetes?
____	____	6. Do you have emphysema?
____	____	7. Do you feel pain in your chest when you engage in physical activity?
____	____	8. In the past month, have you had chest pain when you were not doing physical activity?
____	____	9. Do you ever lose consciousness or do you ever lose control of your balance due to chronic dizziness?
____	____	10. Are you currently being treated for a bone or joint problem that restricts you from engaging in physical activity?
____	____	11. Has a physician ever told you or are you aware that you have high blood pressure?
____	____	12. Have you had or do you currently have Cancer? If so, what type _____
____	____	13. Has anyone in your immediate family (parents/brothers/sisters) had a heart attack/stroke or cardiovascular disease before age 55?
____	____	14. Has a physician ever told you or are you aware that you have a high cholesterol level?
____	____	15. Do you currently smoke?
____	____	16. Do you have chronic bronchitis or asthma?
____	____	17. Are you over the age of 55?
____	____	18. Do you have any other medical condition that would limit your participation in an exercise program? Specify:

_____

_____

YES to #1 - 12 or two or more questions: You must have a Physician's Release Form

No to all questions: Please schedule a Fitness Assessment and Program Orientation prior to beginning exercising.

Please note: If your health changes so that you then answer YES to any of the above questions, tell your Health Fitness Instructor/Clinical Exercise Physiologist professional at the Wellness Center and ask he/she whether you should change your physical activity program.

I have read, understood, and completed this questionnaire. Any questions I had were answered to my full satisfaction.

Signature: _____ Date: _____

Staff Signature: _____ Date: _____