MEMBERSHIP REGISTRATION

TriHealth Fitness Center at 191 Rosa Parks St.

Personal Information

Last Name	**First Name**	**Nickname**
Gender ☐ Male ☐ Female ☐ Other or prefer not to say		**Date of Birth** / /
Home Mailing Address	**City**	**State** **Zip**
Email		**Phone #**
Emergency Contact		**Phone #**
Employer ☐ First Student ☐ Mass Mutual ☐ Staffmark ☐ Other _____		

Membership Options

Daily / Guest Access - $5 ☐ One-day

Monthly Access - $30 ☐ Recurring ☐ 1-month PIF ☐ 3-month PIF ☐ 6-month PIF ☐ 12-month PIF

I authorize the TriHealth Fitness Center to automatically charge my selected payment method for membership renewals and other related charges. I understand that I can update or cancel this authorization at any time with thirty (30) days written notice.

Initials: _____ **Date:** _____

* Membership is available to all employees with access to 191 Rosa Parks (Spouses & dependents are **not** eligible for membership)
* No initiation or cancellation fees, and no long-term contracts required * Thirty (30) day notice must be given prior to cancellation
* All major bank companies accepted (AMEX, Discover, MasterCard, Visa, & digital wallets) * Cash and checks are not accepted

I verify that all information noted above is accurate and I understand that it is my responsibility to update the fitness staff of any changes in health status that would alter my ability to safely participate in a fitness program.

Signature: _____ **Date:** _____

For Office/Staff Use Only	☐ *New / First-time Member* ☐ *Renewal or Updating PW* ☐ *Guest/Prospect*	PCF Needed? ☐ *Yes* ☐ *No*

TriHealth

TRIHEALTH FITNESS CENTER AT 191 ROSA PARKS ST.
INFORMED CONSENT AND WAIVER
FOR FITNESS CENTER PARTICIPATION

As a participant in the **TriHealth Fitness Center**, fitness screenings and/or exercise activities, I understand and I have been informed that my **voluntary participation** in health promotion and fitness programs and special events including, but not limited to, the use of weights, number of repetitions and use of any and all machinery, equipment, all apparatus designed for exercising and the associated **facilities shall be the participant's sole responsibility** during all times of Fitness Center use. I also understand and have been informed that participation in any of the events noted above **does pose the risk of serious injury or other adverse health consequences, including death.** I agree to **self-limit my exertion through good judgment** and to **terminate any physical activity immediately, if it exceeds my personal limitations,** whether or not it exceeds the activity level recommended by the staff or prescribed by my physician. I hereby consent to, and permit emergency medical treatment in the event of any injury or illness.

If requested to obtain written consent from a personal physician, **I verify** that I have been **evaluated by a physician,** and I have been approved to participate in the programs and exercise activities as stipulated on my Physical Consent Form which is attached. If my current fitness status limits my activities, it has been indicated on my Physical Consent Form. These **limitations** have been **fully explained to me, and I understand and assume the risk** of injury and other adverse health consequences, including death, if I exceed the exercise and dietary guidelines recommended by my physician.

I understand it is my **responsibility** to seek and to continue to **receive medical evaluations** from my personal physician to determine if there are any medical conditions or injuries that could limit my participation in fitness or health promotion activities. **I agree to notify the staff changes** in health status, physical injuries, pregnancy, hospitalizations, surgery or additional physical and medical limitations, or additions/changes in medication recommended by my physician that may affect my participation in fitness or health promotion activities. I understand that for any new medical conditions or injuries noted above, **written consent from my personal physician** may be **required prior to resuming** activities. I understand my activities may be modified.

In consideration for my participation in fitness programs, special events, and exercise activities, **I voluntarily assuming the risk** of any injury, loss and/or adverse health consequence. I, for myself, my heirs, executors, administrators and assignees, hereby **release TriHealth, Inc., Bethesda Healthcare, Inc.,** and their officers, directors, employees and their affiliates entities from any and all claims, liabilities or demands of any kind arising from an injury, loss, or adverse health consequence, including death, related to my participation in fitness or health promotion activities, except to the extent resulting from its or their negligence or willful misconduct.

Subject to these conditions, I affirm that I have read, understand and agree to terms set forth above and I wish to participate in fitness and / or health promotion programs, exercise activities and special events.

Name (Print): _____

Signature: _____ *Date:* ____/____/_____
Member/Guest Signature

Witness: _____ *Date:* ____/____/_____
Staff Signature

TriHealth