



Fitness

ENROLLMENT FORM (FULL TIME OR PART TIME EMPLOYEE)

NAME: _____ EMPLOYEE # _____

ADDRESS: _____ CITY: _____ STATE: _____

ZIP: _____ HOME PHONE #: _____ DEPARTMENT: _____

FAMILY MEMBER NAME: _____ MEMBER # _____

FAMILY MEMBER NAME: _____ MEMBER # _____

FAMILY MEMBER NAME: _____ MEMBER # _____

FAMILY MEMBER NAME: _____ MEMBER # _____

I authorize Southeast Health to payroll deduct \$10.00 each pay period as a membership fee plus \$5.00 a pay period for each member of my family. I understand that I must maintain enrollment to Southeast Health Fitness for a minimum time frame of 6 months. At the end of 6 months my membership and my family membership will be automatically renewed. I also understand and acknowledge that Southeast Health can revoke membership at anytime and that my membership will be cancelled immediately upon my termination. Notice to cancel must be given 30 days in advance.

*** I agree to pay a \$20 activation fee per membership if the member is signing up for a 24 Hour Membership.**

Employee Signature

Date

RELEASE OF LIABILITY

I understand and agree that, in return for the privilege of using Southeast Health Fitness; I release Southeast Health from liability of responsibility for any injury I may sustain through my use of the facility. I understand that the use of an exercise facility contains inherent dangers and the risk of injury. I understand and agree that, while Southeast Health intends to provide a safe and healthful exercise facility, Southeast Health or its representatives are not responsible for injuries that I may sustain through the use of the facility, equipment and/or machines, or unsafe conditions caused by others or the conduct of others. I understand and agree that I am solely responsible for learning the proper use and operation of all the equipment and machines and for checking each piece of exercise equipment or machine before using it to ensure it is operating properly.

I understand and acknowledge that is highly recommended that I consult with a physician of my choice before participating in any physical activity or exercise. I understand and acknowledge that I have been advised of the recommendation for obtaining permission or clearance from the physician of my choice before participating in any physical activity or exercise. I represent that I have obtained permission or clearance from my physician of choice before participating in any physical activities or exercise or that I have voluntarily decided to participate without such permission or clearance from my physician of choice, for which I accept full responsibility.

I have received a copy of the rules and professional appearance guidelines governing admission and use of the Southeast Health Fitness. I have read the rules and guidelines and I understand them to be requirements for the use of the facility. I agree to fully comply with all such rules and guidelines that exist now or that may be amended. I understand that the use of Southeast Health Fitness is a privilege and not a right, and Southeast Health may discontinue any use at any time deemed necessary to maintain a safe environment for others or myself or if I do not comply with established rules and /or guidelines.

I am aware there will be NO SUPERVISION OR ASSISTANCE DURING CERTAIN HOURS. In the event I sustain an injury, become unconscious, suffer a stroke, heart attack, or other condition that requires immediate assistance, I am aware there will likely be no one to respond to the emergency and Southeast Health has no duty to provide assistance to me. I understand the surveillance cameras and panic buttons are not monitored continuously, and help will not be available during non-staffed hours. I understand alert pendants will be available that will connect to 911 when activated. I understand Southeast Health HIGHLY recommends I have a workout partner accompany me while at the club.

Member Signature

Date

Witness

Date

HR USE: Effective Date: _____ HR Signature: _____