



# Wellness Center Membership Application

FOR OFFICE USE ONLY				
	Pool	Regular	Premier	
Dis.	ND	Ind.	2 Per.	Family
Initiation Fee: \$ _____				
Pro-Rated Amount: \$ _____				
First Payment: \$ _____				
Total Payment: \$ _____				
Starting Date: _____				
Expires On: _____				
Staff Initials: _____				
Member Barcode #: _____				

Last Name		First Name	Middle Initial	Date of Birth	
Street Address				Home Phone	
City		State	Zip Code	Cell Phone	
Email Address				Work Phone	Ext.
In Case of Emergency, Contact		Relationship to Me (father, child, etc.)		Contact Phone (H/C/W)	

Nature of Disability (if any)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has your doctor imposed any restrictions?

\_\_\_ Yes    \_\_\_ No                      If yes, please explain below:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you been a member before?

\_\_\_ Yes    \_\_\_ No                      When? \_\_\_\_\_

How did you hear about us?

\_\_\_ Doctor        \_\_\_ Physical Therapist    \_\_\_ Friend/Family

\_\_\_ Front Sign    \_\_\_ Other League Program

\_\_\_ Other \_\_\_\_\_

Are you or your family interested in volunteering?

\_\_\_ Yes    \_\_\_ No

Area of interest: \_\_\_\_\_

The following demographical information is being requested to gather statistical data for reporting to the United Way of Central Maryland. Your information will be held in strictest confidence and will only be used to determine how The League can better serve you and maintain funding by the United Way.

Residency:	Race:
___ I am a city resident	___ ___ African/American
___ I am a county resident	___ ___ Asian
_____ County	___ ___ Caucasian
	___ ___ Hispanic/Latino
	___ ___ Native American
Gender:	___ ___ Pacific Islander
___ Male                      ___ Female	___ ___ Other: _____

Household Income:

___ \$0-\$15,000	___ \$15,001-\$30,000
___ \$30,001-\$50,000	___ \$50,001-Over

WAIVER:

I understand that The League for People with Disabilities, Inc. assumes no responsibility for injuries or illnesses which I may sustain as a result of my physical condition or resulting from my participation in an exercise program, the use of any equipment, or other activities. I expressly acknowledge on behalf of myself and my heirs/clients that I assume the risk for any and all injuries or illnesses which may result from these activities. I hereby release and discharge The League, its agents, assigns, and/or employees from any and all claims for injury, illness, death, loss, or damage which I may suffer as a result of my participation in these activities.

I understand that The League is not responsible for personal property lost or stolen while members and/or program participants are using The League facilities or are on The League property. I also understand that if I change my mind about membership, I have up to three business days to obtain a full refund, but will receive no refund after those three days.

Signature of Primary Member

Date

Signature of Parent/Guardian (if member is under 18 or requires an aide)

Date