MAC
Your Area Agency on Aging

APPLICATION FOR MEMBERSHIP
RICHARD A HENSON WELLNESS CENTER

909 Progress Circle, Salisbury MD 21804
410-742-0505 ext. 130
Fax : 410-742-0525
www.macinc.org

Gym Hours: Mon-Fri 8:00am-4:00pm

Name		
FIRST NAME	M.I.	LAST NAME

Address		
STREET		
CITY	STATE	ZIP CODE
CELL PHONE	HOME PHONE	
EMAIL		

Emergency Contact Information		
NAME	RELATIONSHIP	PHONE NUMBER

Personal Information		
BIRTHDATE (mm/dd/yyyy)	GENDER	RACE (Circle One) WHITE BLACK HISPANIC ASIAN PACIFIC ISLANDER AMERICAN INDIAN ALASKAN

Additional Info
Are you a cancer survivor? YES:__ NO:_

I HAVE READ, UNDERSTAND, AND AGREE TO ALL OF THE INFORMATION PROVIDED ON THE BACK OF THIS FORM. I ALSO UNDERSTAND AND AGREE THAT THE CONDITIONS OF MEMBERSHIP AND THE ASSUMPTION OF BASIC WAIVER & RELEASE OF ALL CLAIMS ARE IN EFFECT THROUGHOUT THE DURATION OF MY MEMBERSHIP WITH THE RICHARD HENSON HEALTH AND WELLNESS FACILITY OF MAC. LASTLY, I UNDERSTAND AND AGREE THAT IF THE MEMBERSHIP IS INTERRUPTED FOR ANY REASON THESE AGREEMENTS WILL REMAIN IN EFFECT DURING THE PERIOD OF INTERRUPTION AS WELL AS AFTER THE MEMBERSHIP IS REINSTATED.

SIGNATURE_____ **DATE**_____

Health History

REQUIRED

Medications you're currently taking:

_____

_____

_____

_____

Medical background [Include past and present surgeries, injuries, pain areas, etc,)

_____

_____

_____

Have you been to physical therapy in the past? If so, for what, and which physical therapy practice?

_____

_____

What are your goals?

_____

_____

_____

_____

What is your exercise capability and status?

_____

_____

_____

Membership Policies

SCHOLARSHIP POLICY

It is the goal at MAC Incorporated to improve and maintain physical, social and mental wellness services in the active adult communities we serve, regardless of residents' ability to pay. A waiver or reduction of fees is available subject to facility and program capacity, and demonstrated need, without regard to race, color, nationality, religion, gender, age, or disability.

Initials

CONDITIONS OF MEMBERSHIP

All members are required to sign in using our electronic check-in procedure to access and use the wellness facility and programs. Members are STRICTLY PROHIBITED from wearing any variety of open toe footwear/sandals/shoes in the gym facility. Members are required to help prevent the spread of germs by wiping down equipment after use by wiping equipment with anti-bacterial wipes provided by the facility. Members should stay home when feeling ill to prevent the spread of germs. Joiner's fees are non-refundable. As a member of the Richard A. Henson Wellness Center of MAC Incorporated you are agreeing to follow the policies, procedures and appropriate behaviors for the safety and comfort of all members and guests.

Initials

PERSONAL TRAINING CANCELLATION POLICY

Once a session has been made, cancellation requires a 24-hour notice. If cancelled 24 hours in advance of the session time, there is NO charge. If cancellation is made LESS than 24 hours prior to the session time, the member WILL be charged the full amount.

Initials

ASSUMPTION OF RISK WAIVER AND OF ALL CLAIMS

I RECOGNIZE AND ACKNOWLEDGE THERE ARE CERTAIN RISKS OF PHYSICAL INJURY TO PARTICIPANTS IN THE ACTIVITIES OF MAC INCORPORATED AND VOLUNTARILY AGREE TO ASSUME FULL RESPONSIBILITY FOR AND RISK OF BODILY INJURY, DEATH OR PROPERTY DAMAGES OR LOSS, regardless of severity, that I may sustain from my presence in, upon or about the premises or while using or observing the premises or any facilities or equipment or participating in any program affiliated with the Richard A. Henson Wellness Center of MAC Incorporated without respect to location.

I, FOR MYSELF, ANY PERSONAL REPRESENTATIVES, ASSIGNS, HEIRS AND NEXT OF KIN, HEREBY FULLY RELEASE, WAIVE, DISCHARGE AND COVENANT NOT TO SUE the

Richard A Henson Wellness Center of MAC Incorporated, their respective officers, directors, Trustees, members, volunteers, employees or agents (the "Releasees") and each of them from any and all claims for injuries, damages or loss that I may have or which may accrue to me from my presence in upon or about the premises or while using or observing the premises or any facilities or equipment or participating in any program affiliated with the Richard A. Henson Wellness Center of MAC Incorporated without respect to location.

I HEARBY AGREE TO INDEMNIFY AND SAVE AND HOLD HARMLESS the Releasees and each of them from any loss, liability damage or cost they may incur from my presence in, upon or about the premises or while using or observing the premises or any facilities or equipment or participating in any program affiliated with the Richard A Henson Wellness Center of MAC Incorporated without respect to location, and whether caused by the negligence of the Releasees or otherwise.

Initials

PHOTO WAIVER

I understand that my photo may be taken by the Richard A. Henson Wellness Center of MAC Incorporated on occasion, and I hereby grant permission for my name and likeness to be used for any legitimate purpose in any media now or hereafter developed by the Richard A Henson Wellness Center of MAC Incorporated.

Initials

ALTER G USE POLICY

If a person requires assistance getting in and out of the Alter G, they must schedule a personal training session, and enter/exit the Alter G within that time (30 minute time slots). If a client is needing a longer session in the Alter G, they must schedule a back-to-back personal training session.

I have received and reviewed all of the above policies.

*Signature*_____ *Date*_____

Physician Release to Participate in an Exercise Program at the Richard A. Henson Wellness Center

To: (Physician's Name) _____
(Clinic Address) _____
(City, State, Zip)_____
(Phone) (Fax)_____

From: (Name) _____
(Address)_____
(City, State, Zip)_____
(Phone) (Fax) _____

Re: (Client's Name_____) (Client's DOB_____)

Dr. _____

Your patient,_____, is planning to begin a membership at the Richard A. Henson Wellness Center at MAC Incorporated. All exercise programs are developed based on the individual's health history, current level of fitness and desired goals. Our fitness instructors hold accredited certifications, as well as CPR and First Aid certifications. We value your input regarding this client's exercise prescription. At this time, we are requesting the release of information that you feel would be beneficial to us in developing a safe and effective exercise program. If you know of any medical reasons that would contraindicate or limit this individual's ability to participate, please indicate your concerns. If you have any question, please call us at 410-742-0505.

- I know of no reason why_____may not participate in an exercise program and fitness testing.
- _____ may participate in an exercise program and fitness testing with the following precautions/limitations:
  _____
- I recommend that_____not participate in an exercise program at this time.

COMMENTS/CONCERNS _____

_____

_____

_____

(Physicians Signature) (Date)

I hereby consent to the release of pertinent information to _____for the purpose of providing a safe and effective area for exercise, as well as designing a safe and effective exercise program. I understand that this information will be kept confidential and only persons involved in the design and implementation of my program will be reviewing this information.

(Client's Signature) (Date)