

**NEW YORK CHIROPRACTIC COLLEGE HEALTH & FITNESS CENTER
MEMBERSHIP APPLICATION/AGREEMENT**

MEMBERSHIP TYPE _____
Circle one **New** **Renewal**

EXPIRATION DATE: _____
(n:new membership2app.docx)

APPLICANT NAME: _____
(Please Print) Last First M.I.

DATE OF BIRTH: _____

ADDRESS: _____

TELEPHONE: HOME _____

WORK _____

(IF STAFF/FACULTY- DEPARTMENT NAME _____

CELL: _____

FAMILY OF STUDENT / STUDENTS CAMPUS BOX #: _____

E-MAIL: _____

FOR HEALTH & FITNESS CENTER MEMBERSHIP APPLICANTS ONLY:
HAVE YOU EVER OR ARE YOU CURRENTLY ATTENDING CARDIAC REHAB? YES _____ NO _____

FOR FAMILY MEMBERSHIP ONLY: LIST YOUR FAMILY MEMBERS BELOW

SPOUSE'S NAME: _____

DATE OF BIRTH: _____

CHILDREN: _____

DATE OF BIRTH: _____

DATE OF BIRTH: _____

DATE OF BIRTH: _____

DATE OF BIRTH: _____

IN CASE OF EMERGENCY, NOTIFY:

PHYSICIAN: NAME _____

TELEPHONE: _____

ADDITIONAL: NAME: _____

TELEPHONE: _____

I, _____ on behalf of the above named, hereby apply for Community Membership to the New York Chiropractic College Health & Fitness Center. In doing so, I understand and agree that:

- * Applications are subject to approval;
- * Membership cards are not transferable;
- * Membership privileges may be revoked for misconduct;
- * Membership fees are non-refundable;
- * It is my/our obligation to become familiar with Health & Fitness Center Policies and Procedures

The above named applicant(s) registering for Community Membership are doing so with the understanding that certain activities require a minimum level of fitness and health (physical, mental and emotional) and each person has a different capacity for participating in these activities.

The above named applicant warrants being physically fit to participate and understands the choice to participate brings with it the assumption of those risks and results which are part of their participation.

They furthermore waive and release the New York Chiropractic College and their staff from all liability for injuries, which may occur while utilizing the Health & Fitness Center and will hold the New York Chiropractic College and its staff harmless for all medical expenses incurred.

SIGNATURE: _____

DATE: _____

FOR OFFICE USE ONLY: PAYMENT INFORMATION

PAID IN FULL _____ PAYMENT PLAN _____ CREDIT CARD _____ CHECK # _____ CASH _____
(AUTHORIZATION#)

AMOUNT PAID _____ RECEIPT NUMBER _____ BALANCE _____