

Welcome to the Duke Fitness Club!

Duke is pleased to bring you the Duke Fitness Club as part of its continuing commitment to promote health and wellness among faculty and staff. The Duke Fitness Club offers you and your family discounted membership to fitness facilities throughout central North Carolina.

The Duke Fitness Club's network of facilities provides comprehensive services, convenient locations and attractive rates for faculty, staff and their families. The enrollment process is coordinated through **LIVE FOR LIFE**, Duke's employee health promotion program.

Eligibility: Those eligible are all Duke University and Health System Faculty and staff, retirees and their spouses or same-sex partners, and dependents. Dependents are family members who are eligible for Duke benefits. More details about who qualifies as a dependent are available online.

To Join: Complete the enclosed application and follow the instructions for submission.

Send your completed enrollment forms to LIVE FOR LIFE through any of the following options:

- Fax: 919-684-1852, ATTN: Duke Fitness Club
- Campus Mail: Duke Fitness Club; Box 3200
- In person: Duke South Red Zone Basement Room 04290
Office Hours: Monday-Friday, 8a.m.-5p.m. (closed Wednesday 12-2p.m.)

A LIVE FOR LIFE staff member will contact you when your enrollment forms have been received to complete the enrollment process.



For more information, please visit our Website at www.hr.duke.edu/fitness or call 919-684-3136 and select option 1.



Effective date: _____



Duke Fitness Club Membership Agreement

Duke Raleigh Hospital Wellness Center (DRHWC)

Please initial each below:

- _____ I agree to a 3-month contract with Duke Raleigh Hospital Wellness Center through LIVE FOR LIFE and month-to-month contract thereafter.
- _____ If I choose to cancel my membership after 3 months, I will complete a cancellation form available from LIVE FOR LIFE. After LIVE FOR LIFE receives my cancellation form; it will take at least four weeks for the cancellation to be effective.
- _____ I agree that payment is arranged for my convenience through payroll deduction; however depending on the payroll cycle, one or two month's payment upfront may be required to begin my membership immediately.
- _____ I agree to allow LIVE FOR LIFE to deduct the membership fees through payroll deduction and I understand that my deduction covers 1 month in advance.
- _____ I agree to notify LIVE FOR LIFE of any change in my name, address, phone number, employment or medical status.
- _____ I agree to present my Wellness Center Membership Card at (DRHWC) front desk with each visit.

Please complete the below. Please print clearly or type.

Employee name (payee:) _____ Duke unique ID: _____
 Duke Address #: _____ Email Address: _____
 Home Address: _____ City: _____
 State: _____ Zip Code: _____
 Office Phone: _____ Home Phone: _____
 Are you a Duke retiree or current employee? _____

If you are current employee, are you paid bi-weekly, monthly or the last day of the month? _____
 Is your position considered faculty or staff? _____

Where is your work location? (Circle one) *Duke University Hospital* *Duke University Medical Center*
Duke University *Durham Regional Hospital* *Duke Raleigh Hospital* Other: _____

- Fitness club membership category: Employee Only Employee + Spouse Spouse Only
- Current Member? Waive initiation fee New member? One-time initiation fee: \$25.00
- Employee fitness club fee is \$10.00 a month.
- Spouse fee is \$18 a month Name of spouse (if applicable): _____
- Total monthly fee: _____ Projected Club Start Date: _____

How did you hear about the Duke Fitness Club at Duke Raleigh Hospital Wellness Center? (Please check all that apply)

- Email Direct mail Another member Information booth
- Website Flyers Orientation Other: _____

Employee Signature _____ Date _____

For LIVE FOR LIFE use only

ALL STAFF (PLEASE INITIAL)	FITNESS STAFF ONLY
Membership type selected	Added to PR Report
Amount pd to LFL \$ Source Pd Date	Added to list serve
Medical Clearance if applicable	Entered into Duke Log
Paperwork faxed to Duke Raleigh Wellness Center – 919-954-3177	Entered into Healthcalc

Duke Raleigh Use Only: Membership #

Bar Code #

Each member must complete a copy of this page

Agreement and Release of Liability

1. In consideration of gaining membership or being allowed to participate in the activities and programs of the (DRHWC) and to use its facilities, equipment, and machinery in addition to the payment of any fee or charge, I do hereby waive, release and forever discharge (DRHWC) and its officers, agents, employees, representatives, executors, and all others from any and all responsibilities or liability for injuries or damages resulting from my participation in any activities or my use of equipment or machinery in the above-mentioned facility or arising out of my participation in any activities at said facility. I do also hereby release all of those mentioned and any others acting upon their behalf from any responsibility or liability for any injury or damage to myself, arising out of or connected with my participation in any activities of the (DRHWC) or the use of any equipment at the (DRHWC).
2. I understand and I am aware that strength, flexibility, and aerobic exercise, including the use of equipment, are a potentially hazardous activities. I also understand that fitness activities involve a risk of injury and even death and that I am voluntarily participating in these activities and using equipment and machinery with knowledge of the dangers involved. I hereby agree to expressly assume and accept any and all risks of injury or death. The risks may include, but are not limited to: (1) injuries arising from my use of any exercise equipment, machines and facilities; (2) injuries arising from my participation in supervised or unsupervised activities and programs on the walking track, exercise room, classroom or any other areas in (DRHWC); (3) injuries or medical disorders resulting from exercising at (DRHWC), including but not limited to, heart attack, stroke, heat stress, sprains, broken bones and torn muscles or ligaments; (4) accidental injuries within the facilities, including but not limited to, the locker rooms, showers and dressing rooms.
3. I do hereby further declare myself to be physically sound and suffering from no condition, impairment, disease, infirmity, or other illness that would prevent my participation in any of the activities and programs of the (DRHWC) or use of equipment or machinery except as hereinafter stated. I do hereby acknowledge that I have been informed of the need for a physician's approval for my participation in an exercise/fitness activity or in the use of exercise equipment and machinery. I also acknowledge that it has been recommended that I have a yearly or more frequent physical examination and consultation with my physician as to physical activity, exercise, and use of exercise and training equipment so that I might have recommendations concerning these fitness activities and equipment use. I acknowledge that I have either had a physical examination and have been given any physician's permission to participate or that I have decided to participate in activity and/or use of equipment and machinery without the approval of my physician and do hereby assume all responsibility for my participation and activities, and utilization of equipment and machinery in my activities.

Date: _____ Signature: _____

Additional Terms

1.1 Enrollment Fee

Membership at (DRHWC) requires a one-time enrollment fee upon joining and monthly membership dues. Membership can be canceled with a 30 day written notice which can be done after the three-month contract period.

Upon acceptance of the Member Application by (DRHWC), the undersigned shall receive membership privileges and agrees to abide by all guidelines and policies of (DRHWC). These policies and guidelines are subject to change in the opinion of the facility management when deemed necessary and reasonable for the best interest of its members. I understand the enrollment fee is a one-time only charge and must be included with my completed application.

1.2 Rights of Cancellation

Cancellation may be granted under the following circumstances: 1) Death – Memberships will be terminated upon notification of death. Written documentation will be required from the executor of the estate. 2) Disability – Memberships may be frozen or canceled with written documentation from member's physician stating that the member is directed to discontinue use of the facility and services. 3) Relocation – Memberships may be cancelled if the member moves more than 30 miles from the facility.

The (DRHWC) must be notified in writing 30 days prior to the cancellation of membership. The refund of membership fees will be prorated in monthly increments.

1.3 Member Acknowledgment

By signing this Member Application, I acknowledge that:

- My membership will renew automatically each month until I provide 30 days written notice of my intention to terminate my membership.
- I agree to make all payments in accordance with the agreed upon payment schedule
- I have received a completed copy of the Membership Application and copy of (DRHWC) Code of Conduct.
- I have been orally advised of my rights of cancellation.
- I understand that a temporary leave of absence or membership freeze can be granted based on illness or other special circumstances as outlined above.
- I acknowledge the existence and the need for a Code of Conduct including those governing the use of (DRHWC) equipment and facilities and participation in the programs and services. I hereby agree to comply with the Code of Conduct and to amendments or additions to them, as (DRHWC) deems necessary.
- I understand that it is my responsibility to inform the Fitness Staff of any changes in my health status.

1.4 Termination Policy

(DRHWC) requires 30 days written notice from the member to terminate membership.

WAIVER:

I assume all risks of personal injury and property damage or loss resulting from or in any way associated with entry upon the Duke Raleigh Hospital Wellness Center property. I hereby release the Duke Raleigh Hospital Wellness Center, Duke University, Duke University Health System and any of their trustees, offices, agents, and employees from every claim, liability, or demand of any kind, on account of any injuries to my person or property that I may sustain arising out of and/or participation in said activities. This waiver shall bind my heirs, my assigns, my personal representatives, and me.

_____ Member's Initials _____ Date

Each member must complete a copy of this page

DFC

Client/Guest Code of Conduct

The staff of the (DRHWC) is committed to providing high quality patient care and a therapeutic environment to provide effective programming for all clients. We are dedicated to maintaining an environment in which each client can feel safe and respected. In order to assure a positive experience, clients are expected to conduct themselves in an appropriate manner at all times while participating in Wellness Center programs. The following standards of conduct apply to all clients during their program participation as well as to all guests during their visit to the Wellness Center.

- 1. The client must conduct himself in an appropriate manner while in a program or within the Wellness Center. Clients are expected to be respectful of other participants and staff.
- 2. Clients may not use profane, abusive or loud and boisterous language while on the premises or engage in any action, which may be discourteous or harmful to others.
- 3. Clients are required to interact appropriately with other clients, staff, guests, vendors and others while on the premises. Their behavior should in no way violate another person’s sense of privacy or dignity.
- 4. Clients may not make threats, fight, or engage in any inappropriate or unwanted physical contact with another person while on the premises.
- 5. Clients suspected to be under the influence of alcohol or illegal drugs would not be allowed admission into the Wellness Center or its programs.
- 6. Clients are encouraged to follow program goals and exhibit full participation in all appropriate program activities.
- 7. Clients are encouraged to respect the program goals of other participants by not encouraging activities contrary to program standards.

I have read the above Code of Conduct and agree to abide by these rules while participating in any (DRHWC) program. I understand that violation of any of these rules may result in disciplinary action or termination of my participation in any program.

Signature

Date

Witness

Date

Each member must complete a copy of this page

**Duke Raleigh Hospital Wellness Center (DRHWC)
Health Status Questionnaire**

Date: _____

Member Name: Dr. Mr. Mrs. Ms. _____

Date of Birth: ___/___/___ Age: _____ Gender: Male Female Phone #: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Physician/Specialist: _____ Physician Phone #: _____

Physician Practice: _____ Physician Fax #: _____

Check YES or NO to the following:

YES NO

Heart Attack ___/___/___

Cardiac Catheterization

Heart Valve Disease

Heart Transplantation ___/___/___

Stroke ___/___/___

Pacemaker/Implantable Cardiac Defibrillator/Rhythm Disturbance ___/___/___

Hypertension and/or taking medication to control blood pressure

High Cholesterol and/or taking medication to control blood lipids

Epilepsy, Uncontrolled Seizures

Diabetes - Type 1 or Type 2; or other endocrine disorder such as Hypothyroidism or Hyperthyroidism

Neurological Disorder (example: Multiple Sclerosis, Parkinson's ALS, etc.)

COPD, Emphysema, Chronic Bronchitis, Chronic Asthma

Burning or cramping sensation in lower legs when walking short distances

YES NO

Heart Surgery ___/___/___

Coronary Angioplasty (PTCA)

Heart Failure

Congenital Heart Disease

Kidney Disease

Do you have any of the following symptoms? If yes, please explain

You experience chest discomfort with exertion: _____

You experience unreasonable breathlessness: _____

You experience dizziness, fainting, blackouts: _____

I am pregnant.

Check all that apply:

I am a man > 45 years of age I am a woman > 55 years of age

What is your current weight? _____ lbs. Height: _____

What is the most you ever weighed, excluding pregnancy? _____ lbs.

I am more than 25 lbs. overweight

I am currently exercising LESS than 1 hour per week?

I have been hospitalized/had surgery in the past six months

If yes, explain: _____

I have a close blood relative who had a heart attack/ heart surgery before age 55 (father/brother) or age 65 (mother/sister)

I smoke or have quit smoking within the past 6 months

Each member must complete a copy of this page

Check all that apply:

- I have been diagnosed with another disease that may effect or limit my exercise (ex: cancer, lupus, etc); Please explain _____
- I have received physical therapy in the last year. If yes, then when ___/___/___ Also, please briefly describe why and how long in months, you received treatment.

- I have leg pain, a bone/joint condition which limits my movement/activity.
- I have muscular problems which could be aggravated by physical activity;
Please explain: _____
- I have arthritis; Please explain: _____
- I rely on the assistance of a walking aid or mobility device (wheelchair, cane, walker, scooter, etc).

List any current medications you are taking: (Attach an additional piece of paper if necessary)

Medication	Reason	Dosage	# of times per day

My primary health and fitness goals are: _____

YES / NO - I verify that I am able to independently gain access to the facility, access freely onto and off of the exercise equipment, utilize the exercise equipment as it was designed for and ambulate in and out of showers and locker room facilities.

YES / NO - I have read and understood the question asked. Any questions I may have had while completing this questionnaire were answered to my satisfaction. I verify that all the information noted above is accurate to the best of my knowledge and I understand that it is my responsibility to notify the Duke Raleigh Hospital Wellness Center Staff of any changes in my medical status.

Employee Signature _____ Date _____
Spouse Signature (if applicable) _____ Date: _____

Staff Use Only

- Cleared to Exercise - Date: _____
- Not Cleared to Exercise- Date: _____
- Physician Approval Requested - Date: _____
- Physician Approval Obtained - Date: _____

Staff Signature: _____ Date: _____
Fitness Assessment Date: _____ Exercise Orientation Date: _____