

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 is 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
Fitness World (FW)

Please initial each below:

- I agree to a 3-month contract with Fitness World 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.
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 Duke ID at Fitness World front desk with each visit.

Please complete the below. Please print clearly or type

Employee name (payee): _____ Duke unique ID: _____

Duke Box #: _____ 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

Fitness club membership category: (circle one) Single OR Employee +Spouse OR Family

Names of family member(s) if applicable: _____

Projected Club Start Date: _____ Monthly Fee: _____

How did you hear about the Duke Fitness Club at Fitness World? (Please check all that apply)

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

Employees Signature _____ Date _____

For LIVE FOR LIFE use only

Table with 2 columns: CSC STAFF INITIALS and FITNESS STAFF INITIALS ONLY. Rows include Membership type selected, Amount pd to LFL \$, Paperwork completed for each family member, etc.

Each member MUST complete a copy of this page.

Informed Consent for Exercise

I desire to voluntarily participate in a Fitness World exercise and fitness program. I understand that exercise sessions may consist of both “aerobic” type activities, which use the large muscle groups in a rhythmical and repetitive manner for a sustained period, as well as muscle resistance type activities such as weight training. I understand that exercise at FW is designed to be exertional, and that such physical exertion has the potential to improve functioning of the cardiovascular and skeletal systems, although specific guarantees of improvement cannot be made. I understand that certain physiological changes occur with exercise, some of which can pose health risks. Changes to expect include increases in blood pressure and heart rate. In rare cases, cardiac complications may occur. I agree to immediately report to a staff member any signs of physical distress or symptoms such as chest pain or unusual shortness of breath. I agree to take personal responsibility for using proper footwear and clothing, always warming up and cooling down with each workout, asking for instructions from an instructor before using equipment, working at an exercise pace appropriate for my fitness level, and acting on adverse signs and symptoms. In consideration of my voluntary participation in FW facilities and programs, I, for myself, my heirs, executors, administrators and assigns, hereby release and discharge FW, LIVE FOR LIFE, Duke University and their agents and employees from any and all demands, causes of action and claims for damages suffered by me as a result of my participation in above mentioned activities. I specifically release FW, LIVE FOR LIFE, Duke University, their employees and associates from all injuries or damages arising from or contributing to any physical impairment or defect I may have, whether latent or patent, and agree that FW, LIVE FOR LIFE and Duke University are under no obligation to provide physical examination or other evidence of my fitness, the same being my sole responsibility.

I have read and understand all policies and procedures of FW, and accept responsibility for abiding by all regulations and policies, which may from time to time be reasonably adopted. I understand my membership is activated once I complete these forms and pay my membership fees.

Signature _____

Date _____

Each member **MUST** complete a copy of this page.

Health History Questionnaire

Please complete the below. Please print clearly or type. *All information will be kept confidential.*

Name _____ Date of Birth ____/____/____

Male or Female _____ Ht _____ Wt _____

Primary Care Physician & Location _____

Primary Care Physician's Phone Number _____ Fax Number _____

List any Medications you are taking _____

To ensure your safety during exercise, please answer the following questions regarding your health.

1. Have you ever had any heart problems or abnormalities? (Please check all that apply)
 No known history Heart Surgery Angioplasty Abnormal Heart Beat
 Heart Murmur Other Heart Conditions Heart Attack
2. Do you smoke? No Yes
3. What is your cholesterol level? Level _____ Date _____ Unknown _____
4. Has a close relative (parent, sibling) had a heart attack before age 65? No Yes
5. Do you have muscle, bone, or joint problems that limit your physical activity in any way? No Yes
6. Do you have high blood pressure? No Yes
7. Are you diabetic? No Yes
8. Has a doctor ever diagnosed you with asthma? No Yes
9. Do you have any type of seizure disorder? No Yes
10. Do you have any type of health concern or problem that would limit or restrict your participation in exercise?
 No Yes
11. WOMEN ONLY: Are you currently pregnant? No Yes

If you answered "Yes" to any of the above questions please provide further explanation: *(attach another sheet if necessary?)* _____

Authorization: I authorize the release of information contained in my health history information maintained at the above listed physician's office to be shared with Fitness World staff in order to obtain clearance for me to exercise. Furthermore, I voluntarily authorize the release of information contained on this form to be sent to the above listed physician's office in order to obtain clearance for me to exercise.

Printed Name

Signature

Date