

Limited Use Membership

THIS MEMBERSHIP LIMITS THE MEMBER TO USING THE WALKING TRACK AND SHOWER FACILITIES ONLY – equipment and classes are not included

Single Membership	\$10.00 per month
Dual Membership	\$15.00 per month

NEW **RENEWAL WITH CHANGES** **Sponsoring only, not a member** **MALE** **FEMALE**

_____ *first name* _____ *middle name* _____ *last name* _____ *DOB (Required)*
 () _____
 _____ *work phone #* _____ *work email* _____ *department name* _____ *campus zip code*
 () _____
 _____ *home phone #* _____ *home address* _____ *city* _____ *state* _____ *zip*
 _____ *emergency contact person* _____ *emergency contact relation* () _____ *emergency contact home #* () _____ *emerg contact work #*

Membership Type	Number of Months	Cash Payment	Employer/Payroll Deduct - /Affiliati
<input type="checkbox"/> Single	<input type="checkbox"/> Ongoing (>12 months)	<input type="checkbox"/> _____ months @ rate \$ _____	Employee - payroll deduct
<input type="checkbox"/> Dual (see reverse side)	<input type="checkbox"/> 12 Months	<input type="checkbox"/> Locker \$ _____	<input type="checkbox"/> The Nebraska Medical Center (2 nd paycheck of month)
<input type="checkbox"/> Change Sponsored Members (see reverse side)	<input type="checkbox"/> 6 Months	1-\$5.00 3-\$10.00 6-\$20.00 12-\$30.00	<input type="checkbox"/> UNMC Monthly Employee (paid last day of month)
Start _____	<input type="checkbox"/> 3 Months	<input type="checkbox"/> Towel \$ _____	<input type="checkbox"/> UNMC Biweekly Employee (paid every other week)
End _____	<input type="checkbox"/> 1 Month	1-\$5.00 3-\$10.00 6-\$15.00 12-\$20.00	<input type="checkbox"/> UMA Employee (paid every other week)
<input type="checkbox"/> SAP # _____ office use only	<input type="checkbox"/> Other # of Months _____	<input type="checkbox"/> Towel Sponsored Member \$ _____	Affiliated Members – cash only
	No payroll deduct for 1 month membership	<input type="checkbox"/> Towel Activity entered	<input type="checkbox"/> Clarkson College Employee
		Subtotal \$ _____	<input type="checkbox"/> Community Alliance
		TOTAL \$ _____	<input type="checkbox"/> Health & Wellness Club (Seniors)
		(no payroll deduct for locker or towels)	<input type="checkbox"/> Metro Credit Union
			<input type="checkbox"/> Midwest Eye Care
			<input type="checkbox"/> Nebraska Aids Project
			<input type="checkbox"/> Patient
			<input type="checkbox"/> Red Cross
			<input type="checkbox"/> UNO Employees & Alumni
			<input type="checkbox"/> V.A Medical Center
			<input type="checkbox"/> Other _____

Contract Agreement

I understand this is a binding contract and that I must pay the full amount of the membership for the number of months I indicated above. I understand I need a doctor's slip (stating I am unable to continue my exercise program) to be released from my contract.

Signature

Date

Employee Payroll Deduction Authorization

I hereby authorize the Center for Healthy Living and UNMC/The Nebraska Medical Center/UMA (my employer) to deduct membership fees from my paycheck for the total amount of my and or my sponsored member's membership fees. Upon leaving UNMC/ The Nebraska Medical Center / UMA, I understand any cards used to access the facility (ID or CFHL membership cards) will be voided. **I understand that I am liable for the full amount of the membership, which may require deducting any remaining unpaid portion from my last paycheck.**

Employee Signature

Date

QFC ONLY **DB** **Odyssey** **PAR-Q/Receipt** **Med-Clear** Staff Initials _____ Date _____ **Photo** Staff Initials _____ Date _____

Sponsored Member #1 (Dual)

Dual Membership: Member + (1) adult

Please list primary member if different than employee on reverse side

Primary Member: _____
last name first name middle name

Sponsored by Membership Coordinator

Towel fees - 1(month)\$5.00 3(months)\$10.00 6(months)\$15.00 12(months)\$20.00
 Locker fees - 1(month)\$5.00 3(months)\$10.00 6(months)\$20.00 12(months)\$30.00

Towel Fees \$ _____
 Locker Fees \$ _____

Towel Activity added _____

NEW RENEWAL WITH CHANGES DROP

MALE FEMALE

first name middle name last name DOB (Required)
 (_____) _____
work phone # work email department name campus zip code
 (_____) _____
home phone # home address city state zip
 _____ (_____) (_____) _____
emergency contact person emergency contact relation emerg contact home # emerg contact work #

OFFICE USE ONLY	DB/Odyssey	PAR-Q/Receipt	Med-Clear	Staff Initials _____	Date _____	Photo	Staff Initials _____	Date _____
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