

985530 Nebraska Medical Center
Omaha, NE 68198-5530

UNIVERSITY OF
Nebraska Center for
Medical Center **Healthy Living**
http://www.unmc.edu/cfhl

Phone: (402) 559-5254
Fax: (402) 559-9609

located at 3908 Jones Street

Patient Membership

Use of all equipment and fitness classes included in membership

New members only: We'll need to take a photo to make a membership card.

Sybase # _____



Single	\$25 per month
Dual	\$40 per month
A Medical Clearance and or PARQ (Patient Activity Readiness Questionnaire) must be completed	

NEW Sponsoring only, not a member MALE FEMALE Sybase # _____

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 # _____

Membership Type	Number of Months	Payment Type	Patient Type
<input type="checkbox"/> Single <input type="checkbox"/> Dual (see reverse side) Start _____ End _____	<input type="checkbox"/> _____ x _____ Months Rate	<input type="checkbox"/> Cash / Check \$ _____ <input type="checkbox"/> Locker \$ _____ 1-\$5.00 3-\$10.00 6-\$20.00 12-\$30.00 <input type="checkbox"/> Towel \$ _____ 1-\$5.00 3-\$10.00 6-\$15.00 12-\$20.00 <input type="checkbox"/> Towel \$ _____ <u>(sponsored member)</u> <input type="checkbox"/> Locker \$ _____ <u>(sponsored member)</u> <input type="checkbox"/> TOTAL \$ _____	<input type="checkbox"/> Cardiac <input type="checkbox"/> Diabetes <input type="checkbox"/> Pulmonary <input type="checkbox"/> RA & EX Study (P T Research) <input type="checkbox"/> Spinal <input type="checkbox"/> Other _____ Specify _____

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 _____
 Doctor/ Therapist Name: _____
 Office/Clinic Phone #: _____ Fax #: _____
 Date Med Clearance Sent _____ Date Med Clearance Rec'd _____

