Last Name ____________________

BRANCH NUMBER | MEMBERSHIP NUMBER | JOIN DATE

An Initiative of
Greenville Hospital System University Medical Center
and YMCA of Greenville

Membership Application

NAME | BIRTHDATE | GENDER

FIRST | M.I. | LAST NAME | D.O.B. | MALE or FEMALE

RESIDENCE

STREET

CITY | STATE | ZIP CODE

TELEPHONE NUMBERS/EMAIL ADDRESS

PHONE ( ) | WORK PHONE ( )

EMAIL ADDRESS | CELL PHONE NUMBER ( )

EMERGENCY CONTACT

NAME

PHONE NUMBER ( )

EMPLOYER

COMPANY NAME

FOR OFFICE USE ONLY

MEMBERSHIP TYPES AND PAYMENT METHODS

Adult

Family

Payment Plan: *Annual* *Draft*

Key Tag Number

Name____________________

Name____________________

Name____________________

Name____________________

BACKGROUND

PATH strives to provide membership and services to all who desire to participate. The following questions help us know the people we are serving.
Answering these questions is voluntary and kept confidential.

HOUSEHOLD INCOME

- ❏ UNDER $15,000
- ❏ $15,000-$24,999
- ❏ $25,000-$34,000
- ❏ $35,000-$49,999
- ❏ $50,000-$74,999
- ❏ $75,000-$99,000
- ❏ $100,000-$149,999
- ❏ $150,000 or more

ETHNICITY

- ❏ Caucasian
- ❏ African American
- ❏ Hispanic
- ❏ Native American
- ❏ Asian/Pacific Islander
- ❏ Other____________________

To help us serve you better, please fill out the following information:

How did you hear about PATH?

❏ Advertisement ❏ Health Fair ❏ Rejoining ❏ Corporate Members ❏ Direct Mail ❏ Program Participant ❏ Internet ❏ WalkIn/DriveBy

❏ Employer ❏ Friend ❏ Misc. ❏ Doctor Referral____________________ ❏ Employee ❏ MGM____________________

Name of Doctor Who Referred You | Name of Member Who Referred You

What is your reason for joining PATH?

❏ Programs ❏ To Get In Shape ❏ Competitively Priced ❏ Referred By A Friend ❏ Corporate Partner/Company Health Fair

❏ Convenient Location ❏ Doctor's Referral ❏ To Meet New People ❏ Variety of Programs ❏ Wellness Works ❏ Previous Visit/Expe.

HOUSEHOLD * Proof of dependency/joint status may be required | EMPLOYER / SCHOOL

NAME (FIRST AND LAST, IF DIFFERENT)	BIRTHDATE	GENDER	ENTER Employer on the line below (if applicable).
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		

PATH Partners Achieving Total Health

An Initiative of
Greenville Hospital System University Medical Center
and YMCA of Greenville

Membership Application

BANK DRAFT AUTHORIZATION

NAME OF BANK CUSTOMER

Name

ROUTING AND ACCOUNT NUMBERS

Bank Transit Routing No.:

Depositor's Account No.:

MAILING ADDRESS OF BANK CUSTOMER (If different from address on front)

STREET	CITY	STATE	ZIP CODE

I have given authority to ____ (Full Name of Bank) to honor preauthorized checks drawn by you on my account for membership payments as indicated above. It is understood that your sending of a preauthorized check to the bank as a payment becomes due shall constitute valid notice of such payment due on this membership. When the bank honors the check by charging my account, such check shall constitute my receipt for the payment. Should any preauthorized check not be honored by said bank when received by them, then it is understood that the payment is to be made by one in the amount of said payment.

❑ Voided Check Attached

SIGNATURE OF BANK DEPOSITOR AS SHOWN ON BANK RECORDS.

PATH BANK DRAFT/MEMBERSHIP AGREEMENT

1. It is my complete understanding that if I wish to terminate or change my membership in any way, I must give the "Home" PATH Facility a 30 DAY written notice. I understand that I must turn in all of my membership cards upon termination.

2. The bank draft membership is a continuous membership plan. I understand that this membership will remain in effect for as long as I retain the membership card issued to me.
3. If PATH membership rates change, I understand that I will receive at least four weeks notice prior to any such change.
4. Should any membership draft not be honored by my bank for any reason, I realize that I am still responsible for that payment plus a service charge applied by the "Home" PATH Facility. This is in addition to any service fee my bank may charge.
5. Membership cards remain the property of PATH and must be surrendered upon demand of that institution.

I understand that the PATH Facility assumes no responsibility for injuries which I may sustain as a result of my physical condition or resulting from my participation in any athletic activities, sports programs, the use of any equipment, exercise or other activities. I expressly acknowledge that I assume risk for any and all injuries and illnesses that may result from participation of these activities. In consideration of the privileges of joining the PATH, I hereby voluntarily release and discharge the PATH Facility, its agents, servants and employees from any and all claims for injury, illness, death, loss or damage that I may suffer as a result of my participation in these activities. I understand the PATH Facility is NOT responsible for personal property lost or stolen while members and/or program participants are using PATH facilities or on PATH premises.

Signature of Member____ Date _________________________

Signature of Staff____ Date _________________________

PHOTOGRAPHY RELEASE

I understand that any person on my membership may be photographed, videotaped, and/or interviewed for the purpose of PATH promotional use.

Parent/Guardian Signature: ____