Last Name _____

BRANCH NUMBER | MEMBERSHIP NUMBER | JOIN DATE

PATH Partners Achieving Total Health

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

Membership Application

NAME

FIRST	M.I.	LAST NAME	BIRTHDATE D.O.B.	GENDER 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

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_____

FOR OFFICE USE ONLY

MEMBERSHIP TYPES AND PAYMENT METHODS

Adult

Family

Payment Plan: *Annual* *Draft*

Key Tag Number

Name_____

Name_____

Name_____

Name_____

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_____ (Name of Doctor Who Referred You) ❑ Employee ❑ MGM_____ (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).
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		

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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: _____

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Health History Questionnaire

This questionnaire has been developed in an effort to keep your exercise experience safe. Please answer the following questions as accurately as you can. Many conditions and medications can affect your health while exercising. Your responses will be treated in a confidential manner. We recommend you check with your physician before starting an exercise program.

Name: _____ _____ _____
First *Middle* *Last*

Gender: ☐ Male ☐Female D.O.B: ____/ ____/ ____ Age: _____ Height: _____ Weight: _____

Address: _____ City/State/Zip Code: _____

Phone - Home: _____ Work: _____ Cell: _____

E-mail address: _____

In case of emergency, contact: _____ Phone: _____

Doctor's name: _____ Phone: _____

Date of last physical:_____/_____/_____ Date of Stress Test: (if performed) _____/_____/_____

Medical History and Current Symptoms(do you now or have you had in the past)		
☐ Yes	☐ No	Heart problems: heart attack, bypass, angioplasty, stent, angina
☐ Yes	☐ No	Heart failure
☐ Yes	☐ No	Stroke or TIA
☐ Yes	☐ No	Blockage in artery to: legs, neck or kidney
☐ Yes	☐ No	Chest pain, heaviness, tightness or burning (angina)
☐ Yes	☐ No	Dizziness or fainting (syncope)
☐ Yes	☐ No	Unusual fatigue or shortness of breath (dyspnea) at rest or with normal activity
☐ Yes	☐ No	Pain or tightness in hips or calves with walking (claudication)
☐ Yes	☐ No	Diabetes. If yes, what type:
☐ Yes	☐ No	Seizure disorder
☐ Yes	☐ No	Breathing or lung problems
Other Symptoms (please answer all questions)		
☐ Yes	☐ No	Pregnancy (now or within the last 3 months)
☐ Yes	☐ No	Recent surgery or any other condition that might hinder you from exercise
☐ Yes	☐ No	Thyroid problems
☐ Yes	☐ No	Muscle, joint or back problems
☐ Yes	☐ No	Mental/nervous disorder
☐ Yes	☐ No	Current cigarette smoker or quit within the last 6 months
☐ Yes	☐ No	High blood pressure (140/90 or higher) or taking medicine to lower blood pressure
☐ Yes	☐ No	High blood cholesterol (240 or higher) or taking medicine to lower cholesterol level
☐ Yes	☐ No	Family history of early heart disease (father/mother/brother/sister before age 60)
☐ Yes	☐ No	Excess Weight ("20 extra pounds" especially around the waist)
☐ Yes	☐ No	Other symptoms not listed:

Summary explanation of health history (if needed) _____

_____

Physical activities I enjoy are _____

My health goal(s) is/are _____

I do understand that there is a risk of injury associated with participation in the PATH Exercise Program and I certify that I am in good physical condition and have no disabilities that hamper my participation. I do hereby assume full responsibility for any and all damages, injuries, or losses that I may sustain or incur, if any, while attending or participating in any PATH Exercise Programs. I hereby waive all claims against the YMCA of Greenville, GHS Life Centers, its instructors, or partners of said program, individually, or otherwise, for any and all claims for injuries or damages that I might sustain. I certify that all of the information provided on this application is correct and true.
Your signature authorizes a YMCA/Life Center staff member to obtain a medical clearance from your physician, if necessary.
It is the responsibility of the member to update this form on a yearly basis and to notify a fitness specialist of any changes.

Signature _____ **Date** _____

ALL PARTICIPANTS MUST SIGN. PARENT OR GUARDIAN MUST SIGN IF THE PARTICIPANT IS UNDER 18.

Code of Conduct:

The Life Center Health & Conditioning Club and the YMCA strive to provide a safe and enjoyable environment to all our members and guests. Respectful and mature behavior is expected at all times. Inappropriate behavior may result in suspension or termination of membership privileges. Management reserves the right to terminate members for non-payment of membership dues, for inappropriate behavior or other reasons as determined at the sole discretion of the YMCA and or Life Center Health & Conditioning Club staff. To ensure the comfort and safety of everyone, we have set forth the following expectations for all individuals who use the facility.
Behaviors that violate the Life Center Health & Conditioning Club and YMCA include, but are not limited to:

- **Any acts of violence;**
- **Smoking or illegal drug use in or outside the YMCA or Life Center Health & Conditioning Club property;**
- **Use of vulgar language, swearing, name-calling or shouting;**
- **Harassment or intimidation by words, gestures, body movement or menacing behavior;**
- **Possession of any items that can be used as a weapon or as a threat to others;**
- **Careless use or destruction of YMCA or Life Center Health & Conditioning Club property or the property of others;**
- **Usage of the YMCA or Life Center Health & Conditioning Club facility while under the influence of illegal drugs or alcohol;**
- **Disrespect or disregard for others.**

Signature _____

Witness _____ **Date** _____

GREENVILLE HEALTH SYSTEM

EMPLOYEE PAYROLL DEDUCTION AUTHORIZATION FOR LIFE CENTER

NAME	**DATE:**
EMPLOYEE #	
STATUS: ☐ FULL-TIME ☐ PART-TIME	**LOCATION:** ☐ 8021 - GREENVILLE ☐ 7464 - GREER
MEMBERSHIP: ☐ NEW ☐ CHANGE ☐ CANCEL	**MEMEBERSHIP PLAN:** ☐ INDIVIDUAL ☐ FAMILY II ☐ FAMILY PLUS ☐ PATH INDIVIDUAL ☐ PATH FAMILY

INITIATION FEE

☐ I do hereby authorize the LIFE CENTER to deduct $_____ from my payroll divided in 1 2 3 4 (circle one) consecutive pay periods for my LIFE CENTER Initiation Fee.

Employee Signature: _____ Date: ____/_____/_____

BI-WEEKLY DUES

☐ I do hereby authorize the LIFE CENTER to deduct $_____ from my payroll each pay period for my LIFE CENTER monthly dues until such time as I notify the LIFE CENTER thirty (30) days in advance in writing of my intent to cancel my membership.

As a benefit to GHS Employees, I understand that GHS subsidizes a portion of my LIFE CENTER monthly dues and that the portion that GHS subsidizes is taxable and the amount will be reflected on my paycheck. This is due to income and tax laws mandated by the United States government.

Employee Signature: _____ Date: _____/_____/_____

completed by LC staff	BI – WEEKLY AMOUNTS		
DEDUCTION CODE	931	932	933
	LIFE CENTER	PATH CONVERTED	PATH NEW
8000 - INITIATION			
8001 - PATH INITIATION			
8005 - DUES			
8010 - DUES PATH			
8015 - DUES PATH NEW			

Payroll Use:

Date Keyed:	
Keyed By:	

Life Center Use:

Intake Staff:	
Staff Keyed:	
Date Keyed:	
Extension:	