DR. EPHRAIM WILLIAMS
FAMILY LIFE CENTER
A Ministry of the Fellowship of Excitement

Membership No. ☐☐☐☐☐

1. MEMBER INFORMATION—Please Print Clearly

LAST NAME FIRST NAME MI HOME PHONE

CURRENT MAILING ADDRESS CITY STATE ZIP

EMAIL CELL PHONE

BIRTHDATE AGE [ ] F [ ] M DRIVERS LICENSE #

EMPLOYER WORK PHONE (____)

HOW DID YOU HEAR ABOUT US/REFERRED BY?_____

Are you a member of St Paul?_____ How would you rate your eating and exercise habits ? [Excellent] [Good] [Fair] [Poor]
What days of the week do you workout?_____ What part of the facility will you use the most?_____
Are you currently a member of another work out facility?_____

Please list all sub-members including all children. (12 or older will receive a membership card)

FIRST & LAST NAME	BIRTHDATE	M/F	RELATIONSHIP

2. MEDICAL INFORMATION—Please Print Clearly

Family Physician's Name:

Physician's Address:

Physician's Telephone:

Emergency Contact:

Emergency Phone:

Please indicate any special medical condition, medication, or devices that limit physical activity and the specific individual concerned.

3. PHYSICAL ACTIVITY READINESS QUESTIONAIRE (PAR-Q)

Regular physical activity is fun and healthy, and increasingly more people are starting to become more active every day. Being more active is very safe for most people. However, some people should check with their doctor before they start becoming much more physically active. If you are planning to become much more physically active than you are now, start by answering the seven questions in the box below. If you are between the ages of 15 and 69, the PAR-Q will tell you if you should check with your doctor before you start. If you are over 69 years of age, and you are not used to being very active, check with your doctor.
Common sense is your best guide when you answer these questions. Please read the questions carefully and answer each one honestly.

Yes	No	Check YES or NO
☐	☐	1. Has your doctor ever said that you have a heart condition <u>and</u> that you should only do physical activity recommended by a doctor?
☐	☐	2. Do you feel pain in your chest when you do physical activity?
☐	☐	3. In the past month, have you had chest pains when you were not doing physical activity?
☐	☐	4. Do you lose your balance because of dizziness or do you ever lose consciousness?
☐	☐	5. Do you have a bone or joint problem that could be made worse by a change in your physical activity?
☐	☐	6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?
☐	☐	7. Do you know of <u>any other reason</u> why you should not do physical activity?

Consult with your personal physician by telephone or in person before increasing your physical activity or participating in a fitness program. **<u>For your safety, the DEWFLC cannot allow you to exercise in its facilities until we receive a Physician's Approval Form from your doctor.</u>**
Your doctor may fax the Physician's Approval form to Attention: Fitness Staff—DEWFLC***

Signature of Applicant Date

1._____

4. PHOTO RELEASE WAIVER

I hereby consent to and authorize the use and reproduction by DEWFLC, or anyone authorized by DEWFLC, of any and all photographs that have been taken of me and/or my child(ren) this day for any purpose, without compensation to me. All negatives and positives, together with the prints, are owned by the DEWFLC. The DEWFLC reserves the right to use these photographs in any of its print or electronic publications.
I hereby acknowledge that I have read and understood the terms of this release.

MEMBER INITIAL X _____

5. AUTO MONTHLY BILL PAYMENT

Choose one Monthly payment date	Amount of Monthly Payment	First Due Date
6th / 20th		

MEMBER INITIAL X _____

EFT Authorization

I,_____ authorize my bank to make my payment by the method indicated as follows and post it to my account

☐ Checking* ☐ Savings**
☐ MasterCard ☐ Visa
☐ AM Ex ☐ Discover

(*must attach a void check) (attach a deposit slip)**

Account #_____
Expiration Date_____
Number of payments_____
1st Due Date:_____

I understand that I am in full control of my payment and at any time I decide to discontinue this form of payment, I will notify DEWFLC in writing at: 4036 14th Avenue, Sacramento, CA 95820, or P.O. Box 5237, Sacramento, CA 95817, a minimum of thirty (30) days prior to my next contract due date:

Bank Name_____
Bank Address_____
City/State/ Zip_____
Bank Phone _____

DEWFLC has the right to apply a fee on any dues transaction not debiting electronically.

Account holder's signature *Date*

_____

FOR PERSONNEL USE ONLY

Single Membership Rate _____
Couple Membership Rate _____
Senior Membership Rate _____
Family Add on 1 2 3 4 5 _____
Locker # _____ _____
Processing Fee(s) _____
Special Promotion _____

TOTAL MONTHLY INVESTMENT $ _____

Date: ____/____/____
Cash/Check # _____
Authorized Personnel: _____
Total Cards Made: _____