 Start Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Member #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEMBER AGREEMENT**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

LAST NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FIRST NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI: \_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_\_ SEX: (M/F/UNDISCLOSED) MARITAL STATUS: (S/M/UNDISCLOSED)

MAILING ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HOME# (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE: \_\_\_\_\_\_ZIP:\_\_\_\_\_\_\_\_ CELL # (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK# (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By providing your email address you are giving us authorization to send you information via email. Email addresses will only be used by Logan Health Wellness Center.

EMERGENCY CONTACT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE # (\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADDITIONAL MEMBER**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ MEMBER #: \_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DEPENDENT CHILDREN (through age 23)**

NAME SEX BIRTHDATE AGE MEMBER #

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I hereby apply for membership to Logan Health Conrad Wellness Center. I certify that the information set forth in this application for Membership is true and complete to the best of my knowledge and agree to pay fees when due and comply with all rules established by the management**. I understand that membership and billing are not based on attendance or usage and that I am responsible for all monthly fees until I give written notice of my intent to cancel a minimum of 3 business days prior to the first of the month that my cancellation becomes effective**. Fees for temporary memberships are non-refundable. The Member will be liable for payment of all costs incurred by the wellness center in the collection of past due obligations to Logan Health Conrad Wellness Center, including collections services fees up to 40% of balance due, court costs and reasonable attorney’s fees. I understand the risks involved in fitness and sport activities and state that my health warrants participation.

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SIGNATURE (REQUIRED) DATE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE (ADDITIONAL MEMBER) DATE