KAISER PERMANENTE FITNESS CENTER MEMBERSHIP AGREEMENT

1. Eligibility. Membership is available to all Kaiser Permanente employees.
2. Membership Process. To become a member you must complete this Membership Agreement and a Health History Questionnaire, undergo an Initial Consultation, and complete an Exercise/Fitness Center Orientation to be conducted by the Fitness Center staff before using the facility.
3. Term of Membership. The facility is open for use 6am to 10pm Monday-Friday (staffing hours will vary).
4. Membership Fees. No charge! This service is provided at no cost to the employees.
5. Rules and Regulations. The Fitness Center is provided by Kaiser Permanente thus all Kaiser Permanente Standards of Conduct apply while utilizing the facility. All members must agree to observe the rules and regulations of the facility, as may be modified from time to time.
6. Center Access. Facility access is available only to Kaiser Permanente employees who have completed the membership process. Please do not open the door for other employees.
7. Locker Policy. Members may bring their own lock for lockers. Lockers are reserved for day use only. All locks left on lockers overnight will have their lock and contents removed.
8. Personal Property. Members are responsible for their possessions while using the Fitness Center. Kaiser Permanente and Corporate Fitness Works are not responsible for lost or damaged items.
9. Attire Guidelines. To insure the safety of members, proper athletic shoes are required (no open toed sandals). Appropriate exercise attire (e.g., shirts [no bare midriffs], shorts, or exercise tights, warm-up suits, athletic gear, sneakers) are required. Kaiser Permanente and the Corporate Fitness Works staff will monitor and enforce proper attire.
10. Additional Documents. To complete the membership process, all members must sign a Waiver and Release Form, which together will be automatically incorporated into and considered a part of this Agreement.
11. Termination Right. Kaiser Permanente and Corporate Fitness Works reserve the right to terminate this Agreement at any time upon a member's failure to comply with any provision of this Agreement or the rules and regulations of the facility.

By signing below, you are indicating your acceptance of the Facility Rules and Kaiser Permanente Membership Agreement.

Participant Signature:_____ Date:_____

Notice of Privacy Practices

This notice describes how protected medical and health information about you may be used and disclosed and how you can get access to this information. Please review document carefully.

This notice describes the privacy practices implemented at Corporate Fitness Works' managed fitness and wellness centers.

Our Pledge to Protect Your Health Information:

Corporate Fitness Works is committed to protecting your personal health information. In order to maintain the confidentiality of your personal health information collected electronically or otherwise, we create a file for each member in order to provide you with quality service and to comply with all legal requirements. This notice describes the ways in which we use and disclose your health information as well as your rights and our obligations regarding the use and disclosure of your personal health information. We pledge to you that we will take all reasonable measures to ensure that health information that identifies you is kept private and we will follow the terms of the current notice.

Disclosure of Your Health Information:

Corporate Fitness Works' professional fitness staff will use the information about you to provide you with a safe and effective exercise program and to assess and evaluate the health and fitness capacity of center members. We may disclose health information about you to other Corporate Fitness Works personnel involved in your health and fitness program. All reasonable efforts will be made to disclose no more than the minimum information needed to accomplish the intended purpose.

Information obtained from the Health History, Medical Clearance, and other membership related forms, whether created by Corporate Fitness Works personnel or physician(s), will be accessible only to Corporate Fitness Works personnel having a need to know such information. Such information will not be accessible to your employer or any of its personnel.

We may use your name to send membership bills to you or your company; to send you information about the fitness center; to acknowledge participation incentives, awards, and motivational programs or communications. We may post your name within the fitness or wellness facility; unless you specifically object.

We may contact you to provide appointment reminders, information about health and fitness program alternatives or other health and fitness center-related benefits and services that may be of interest to you. You may request, in writing, that such information not be sent to you. We may keep your exercise plan information in an unsecured file, unless otherwise specified by you. You may keep this information secure in your personal possession, if you desire.

We will disclose information about you when required in accordance with federal and state laws, in a lawsuit, for worker's compensation or similar claims, for public health, for health oversight agency activities or to the military, if applicable.

In the event of a change in fitness center management vendors, Corporate Fitness Works will provide your personal health information to the new vendor only if the group agrees to adhere to the privacy practices identified here or with your express written permission.

Your Rights Regarding Medical Information We Maintain About You:

You have the right to inspect and copy your medical information, including your member file. You must submit a written request, signed and dated in order to obtain this information.

> **Right to Amend.** If you feel that your information is incorrect or incomplete, you may ask Corporate Fitness Works personnel to amend the information. You may request an amendment as long as the fitness or wellness center has this information. You must submit your request in writing, signed and dated.

Right to Return of Information. Upon the termination of your membership at a Corporate Fitness Works managed center, you have the right to request that all of your personal health information be returned to you or destroyed. You must submit your request in writing. Upon return of such information, no copies will be retained by Corporate Fitness Works.

Right to Request Confidential Communications. You have the right to specify the manner in which you want us to communicate with you regarding your health information. You must submit your request in writing.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may request a copy of this notice at any time.

Complaints Regarding Your Privacy:
If you believe your privacy rights have been violated, please submit your complaint, in writing, to:

Corporate Fitness Works
1200 16th Street North
St Petersburg, FL 33705
(301) 417-9697

Changes to this Notice:

We reserve the right to change this notice and make the revised notice effective for information we already have about you as well as any future information. We will post a copy of the current notice in the fitness center.

Other Uses of Medical Information:

Other uses and disclosures of information not covered by this notice will be made only with your written permission. You may revoke that permission in writing at any time. Understand that we are unable to take back any permitted disclosures.

Acknowledgment:

I have read and understand the Corporate Fitness Works Notice of Privacy Practices and have been given the opportunity to ask questions.

Signature of Participant	Date	Signature for Corporate Fitness Works	Date

Printed Name	Printed Name

♦ Membership Application and Health History Questionnaire ♦

First Name: _____Last Name: _____

Employee ID Number: _____

Gender: Male ☐ Female ☐ Birth Date: _____

Home Phone: _____ Work Phone:_____

E-mail Address: _____

Address: _____ City: _____

State: _____ Zip: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Home Phone: _____ Emergency Contact Work Phone: _____

Referred? Yes ☐ No ☐ If yes, by whom? _____

1. How did you hear about the fitness center?

☐ Tour
☐ Web page
☐ Newsletter
☐ Word of mouth
☐ Event, please specify: _____
☐ Other, please specify: _____

2. What aspect influenced you to join the fitness center?

☐ Convenience
☐ Amenities/Equipment
☐ Cost
☐ Hours of operation
☐ Programs/Services
☐ Other, please specify:

3. What personal aspect(s) influenced you to join the fitness center?

☐ Weight loss
☐ Stress reduction
☐ Increase energy level
☐ Increase cardiovascular endurance, muscular strength, flexibility
☐ Decrease cardiovascular risk factors (BP, cholesterol, inactivity, family history)
☐ Decrease other health issues (diabetes, thyroid disorder, breathing disorder, bone or joint issues)
☐ Increase self confidence
☐ Social interaction
☐ Other, please specify: _____

4. Physical activity or exercise is defined as accumulating 30 minutes or more of activity per day. Within the last 2 months, how many days a week are you physically active?

☐ 0 ☐ 3-4
☐ 1-2 ☐ 5+

OFFICE USE ONLY	
Date Received:	Medical Clearance Required: Yes ☐ No ☐
Date Approved:	Date Sent:
Health Consultation Date:	Date Received:

Health History Questionnaire

Participant Name: _____ Date: _____

The following questions will be used to assess your health status. Please check the appropriate box if you have experienced any of the following:

Section 1

History

You have had:

- ☐ Heart Attack
- ☐ Heart Surgery
- ☐ Cardiac catheterization
- ☐ Coronary angioplasty (PTCA)
- ☐ Pacemaker, implantable cardiac defibrillator, rhythm disturbance
- ☐ Congenital heart disease
- ☐ Heart valve disease
- ☐ Heart failure
- ☐ Heart transplantation
- ☐ Heart palpitations (irregular heart beat)
- ☐ Heart murmur

Symptoms

- ☐ You experience chest discomfort with exertion
- ☐ You experience shortness of breath at rest or with mild exertion
- ☐ You experience unusual fatigue or dizziness

Other Health Issues

- ☐ You have diabetes
- ☐ You experience breathing disorders (asthma, bronchitis, lung disease)
- ☐ You have bone or joint problems that limit physical activity (i.e. arthritis, bursitis, gout)
- ☐ You have burning or cramping sensation in your lower legs when walking short distances
- ☐ You have musculoskeletal injuries that limit your physical activity
- ☐ You have personal concerns about the safety of exercise
- ☐ You take prescription medication(s)

If so please list name of medication(s):

_____

_____

_____

- ☐ Your blood pressure is ›140/90 mm Hg
- ☐ You are pregnant
- ☐ You have renal or liver disease
- ☐ You have thyroid disorder

Section 2

Cardiovascular risk factors

- ☐ Male older than 45 years
- ☐ Female older than 55 years, have had a hysterectomy, or are postmenopausal
- ☐ You smoke or quit smoking within the previous 6 months
- ☐ You do not know your blood pressure
- ☐ Your blood cholesterol level is ›200mg/dL
- ☐ You do not know your cholesterol level
- ☐ You have a close blood relative who had a heart attack or heart surgery before the age 55 (father or brother) or age 65 (mother or sister)
- ☐ You are physically inactive (i.e., gets ‹30 minutes of physical activity on ‹3 days per week)

Any other conditions or diseases you know which could affect exercise?

_____

_____

_____

Any physical limitations to exercise? _____

_____

_____

If you have checked one or more boxes in section one you must obtain a completed medical clearance from your physician or other appropriate health care provider prior to scheduling a health consultation. Please provide your physician this form as well as the medical clearance below and return to the fitness center once he/she has completed.

Participant Signature Required:

I verify that I have answered these questions truthfully and to the best of my knowledge. If I have a change in my health status from the date it is completed, I will notify the fitness team immediately.

Participant Signature:_____ Date:_____

Medical Clearance Form

Please return Medical Clearance form to:
Kaiser Rockville Fitness Center
Fax: 866-769-3441

PATIENT MEDICAL CLEARANCE RELEASE AUTHORIZATION

Based on my current medical history at this time, I hereby give my permission to release any medical information which may be beneficial for preparing an exercise program at the Fitness Center. Any subsequent exchange of medical information must be approved by me.

_____ _____ _____
Patient's Signature Patient's Printed Name Date

PHYSICIAN'S RECOMMENDATIONS

Dear Doctor:
Your patient is interested in joining a fitness center. We have developed a two-phased program which includes (1) a review of the individual's Health History (2) an individualized exercise program based on the results. Upon completion of your patient's pre-participation health history questionnaire, the Fitness Center team, in accordance with standards established by the American College of Sports Medicine (ACSM), requests your further evaluation and recommendations. On the above form, you will find specific ACSM risk factor(s) that have been identified by your patient that apply to his/her current health status. Due to the marked risk factors, the Fitness Center team requests your further evaluation and recommendations prior to exercise program development and subsequent participation in an exercise program by completing this required Medical Clearance. Additional information that pertains to your patient's ability to participate in an exercise program, other than what is requested, is also appreciated. Thank you for your prompt attention to this matter and supporting your patient's participation in this health-oriented physical activity program.

1. I recommend a diagnostic stress test prior to participation in an exercise program ☐ Yes ☐ No

If yes, please assist your patient with the appropriate referral and/or scheduling of this diagnostic stress test.

2. Total Cholesterol: _____ mg/dl.

   Date performed: _____

3. Recommended Exercise Intensity (Please indicate exercise intensity by one or more of the following methods):

   ☐ Rating of Perceived Exertion (RPE) Scale (_____)
   ☐ Heart Rate Intensity (beats per minute) _____ (_____ max. beats per min.)
   ☐ MET Level (_____ max. MET level)
   ☐ Percent of maximum heart rate: _____% _

4. Recommended Activities (Please check appropriate levels and activities):

   ☐ Exercise not recommended
   ☐ Limited low level cardiovascular exercise
   ☐ No apparent restrictions
   ☐ To be determined by the Fitness Center team

Cardiovascular Exercises	Strength Training/Flexibility Exercises	Recreation Programs
☐ Group Exercise Class	☐ Weight Machines	☐ Basketball
☐ Cross Training Machine	☐ Free Weights	☐ Flag Football
☐ Jogging	☐ Calisthenics (i.e. push-ups)	☐ Martial Arts
☐ Rowing	☐ Stretching Exercises	☐ Racquetball
☐ Stair Climbing Machine	☐	☐ Soccer
☐ Stationary Bike	☐	☐ Softball
☐ Swimming	☐	☐ Tennis
☐ Walking	☐	☐ Volleyball

Comments (Please list any specific activities not recommended or other comments):
_____
_____
_____
_____
_____
_____

PHYSICIAN'S STATEMENT

I, _____ , the undersigned, a qualified and licensed physician, do hereby

certify that I have interviewed and examined _____, and he/she has described the
Name of Participant
type of physical activities and fitness facilities in which he/she intends to participate and use on the premises of

the fitness center. Further, I have examined _____, and it is my professional opinion that
Name of Participant
_____ is, at the present time, physically capable of engaging in those
Name of Participant
activities and utilizing the facilities which he/she has described to me.

Physician Signature: _____

Address: _____

_____

Office Phone No.: _____

Please return Medical Clearance form to:
Kaiser Rockville Fitness Center
Fax: 866-769-3441