Welcome to the Duke Fitness Club!

Duke is pleased to bring you the Duke Fitness Club as part of its continuing commitment to promote health and wellness among faculty and staff. The Duke Fitness Club offers you and your family discounted membership to fitness facilities throughout central North Carolina

The Duke Fitness Club's network of facilities provides comprehensive services, convenient locations and attractive rates for faculty, staff and their families. The enrollment process is coordinated through LIVE FOR LIFE, Duke's employee health promotion program.

Eligibility: Those eligible are all Duke University and Health System faculty and staff, retirees and their spouses or same-sex partners, and dependents. Dependents are family members who are eligible for duke benefits. More details about who qualifies as a dependent is available online.

To Join: Complete the enclosed application and follow the instructions for submission.

Send your completed enrollment forms to LIVE FOR LIFE through any of the following options:

- Fax: 919-684-1852, ATTN: Duke Fitness Club
- Campus Mail: Duke Fitness Club; Box 3200
- In person: Duke South Red Zone Basement Room 04290
  Office Hours: Monday-Friday, 8a.m.-5p.m. (closed Wednesday 12-2p.m.)

A LIVE FOR LIFE staff member will contact you when your enrollment forms have been received to complete the enrollment process.

DUKE HR Human Resources

For more information, please visit our website at www.hr.duke.edu/fitness or call 919-684-3136 and select Option 1.

LIVE FOR LIFE

At Duke

Effective date:_____

Duke Fitness Club Membership Agreement

Duke Health & Fitness Center (DHFC)

Duke History Number: _____ **New/ Renewal/ Reinstated**

Please initial each below:

_____ **I agree to a 3-month contract with Duke Health Fitness Center through LIVE FOR LIFE and month-to-month contract thereafter.**

_____ If I choose to cancel my membership after 3 months, I will complete a cancellation form available from LIVE FOR LIFE. After LIVE FOR LIFE receives my cancellation form, it will take at least four weeks for the cancellation to be effective.

_____ I agree that payment is arranged for my convenience through payroll deduction; however depending on the payroll cycle, one or two month's payment upfront may be required to begin my membership immediately.

_____ I agree to allow LIVE FOR LIFE to deduct the membership fees through payroll deduction and I understand that my deduction covers 1 month in advance.

_____ I agree to notify LIVE FOR LIFE of any change in my name, address, phone number, employment or medical status.

_____ I agree to present my Duke ID at Duke Health Fitness Center front desk with each visit.

Please complete the below. Please print clearly or type.

Employee name (payee:) _____ Duke unique ID: _____

Duke Box #: _____ Email Address: _____

Home Address: _____ City: _____

State: _____ Zip Code: _____

Office Phone: _____ Home Phone: _____

Are you a Duke retiree or current employee? _____

If you are current employee, are you paid bi-weekly, monthly or the last day of the month? _____

Is your position considered faculty or staff? _____

Where is your work location? (circle one) *Duke University Hospital* *Duke University Medical Center*

Duke University Durham Regional Hospital *Duke Raleigh Hospital*

Initiation Fee **(**circle one): Premium* ($200) OR Basic ($75)

*the premium initiation fee is only required if you need a sub maximal stress test completed for clearance

Membership Rate (circle one): *Unrestricted Premium ($53)* *Unrestricted Basic ($48)*

Afternoon Delight Premium ($37) *Afternoon Delight Basic ($31)* *Nights & Weekends Basic ($37)*

Nights & Weekends Premium ($42)

Projected Club Start Date: _____Monthly Fee: _____

How did you hear about the Duke Fitness Club at Duke Health Fitness Club Center? (Please check all that apply)

o Email o Direct mail o Another member o Information booth

o Website o Flyers o Orientation o Other: _____

*Employees Signature*_____ *Date*_____

For LIVE FOR LIFE use only

Fitness Staff Initials Only	Fitness Staff Initials Only
_____ Membership type selected	_____ Added to PR Report
_____ Amount pd to LFL $_____Source_____ Pd Date _____	_____ Added to LS
_____ Paperwork faxed to facility (919-681-7467)	_____ Entered into Duke Log
	_____ Entered into HealthCalc

Special Agreements:

Fitness classifications are based on a self-reported Health History Questionnaire, results of a FST and medical records. **Additional medical follow-up may be recommended based on the information obtained during the FST. Any additional costs related to emergency services or recommended follow-up testing is the sole responsibility of the member**.

If your membership classification changes during your membership contact period, your membership rate is subject to change.

Consumer Rights:
The member has the right to cancel this agreement within three (3) business days of the agreement date. Cancellations must be in writing and submitted to the membership representative. If the member has already had the FST, the cost of the FST will **not** be refunded.

I have read the above provisions and Client Code of Conduct. I understand my rights and responsibilities and agree to all of the terms stated (additional terms on reverse). I agree to be legally bound by all of the membership and payment documents. I further understand that failure to utilize the DHFC does not relieve me of my obligation to pay my membership dues as per my agreement.

_____ _____

Member's Signature Date

Contract Completed By: _____ Membership Representative Initials_____

Additional Terms

1. **Membership Classification**: The member will be responsible for any increase or decrease in fees due to any change in their membership classification. Fees will be prorated in monthly increments.

2. **Additional Testing**: Additional medical follow-up may be recommended based on the information obtained during the FST. Any additional costs related to recommended follow-up testing is the sole responsibility of the member.

3. **Membership Cancellations:** Cancellation may be granted under the following circumstances: 1) **Death -** Memberships will be terminated upon notification of death. Written documentation will be required from the executor of the estate. 2) **Disability** - Memberships may be frozen or canceled with written documentation from member's physician stating that the member is directed to discontinue use of the facility and services. 3) **Relocation -** Memberships may be canceled if the member moves more than 60 miles from the facility. The DHFC must be notified in writing 30 days prior to the cancellation of membership. The refund of membership fees will be prorated in monthly increments.

4. **Membership Freeze:** If the member is temporarily incapacitated, written documentation from your physician will be required for your membership to be frozen in monthly increments. Memberships may be frozen for a one-month period during each membership term (12 months) due to vacation or business. Written documentation within 30 days of the freeze must be submitted to the membership representative.

5. **Membership Lapse:** If a lapse of three months occurs in the membership, the member will be required to repeat payment of the current initiation fee.

6. Transfer: **Memberships are not subject to transfer.**

7. Valuables and Personal Property**: Neither Duke University, Duke University Health System, nor the Center for Living shall be responsible for any loss, theft, or damage to personal property brought into the property.**

8. Unavailability of Facility or Services**: There shall be no right of abatement of the specified term of membership for any reason.**

9. Returned Payment Fee**: A $25.00 service fee will be charged for returned checks, EFT, or credit card charges that are denied.**

10. **Facility Rules**: The member will abide by the rules and regulations of the DHFC. We reserve the right to immediately terminate a membership if rules and regulations are not followed.

11. **Default:** The member is in default of this contract if: 1) any member covered by this contract fails to obey facility rules; 2) we do not receive a payment on or before its due date.

12. **Our Rights Upon Default:** In the event the member defaults on this contract, including the violation of any rule then in effect 1) DHFC may revoke the member's privileges 2) all monies owed according to this agreement become due within 30 business days.

13. **Attorney's Fees:** In the event it becomes necessary to retain the services of an attorney or a collection agency to enforce the terms and conditions of this contract, the prevailing party shall be entitled to recover reasonable attorney's fees and costs or collection fees, including attorney's fees and costs on appeal, from the non-prevailing party.

14. **Applicable Law:** North Carolina law shall govern this contract and venue is proper in Durham County, North Carolina, or in the event of assignment, wherever payments are to be made.

15. **Complete Agreement and Severability:** The terms on both sides of this contract constitute the full agreement between the parties and supersede any oral statements. If any part of this contract is declared unenforceable, the remaining provisions of the contract shall not be affected and shall continue in full force. Upon the acceptance of this application and agreement of membership by DHFC, I hereby agree to accept the terms of this agreement and the rules and regulations adopted by DHFC.

16. **Terms and Conditions are subject to change without notice.**

WAIVER:

I assume all risks of personal injury and property damage or loss resulting from or in any way associated with entry upon the Duke Health & Fitness Center or Duke Center for Living property. I hereby release the Duke Health & Fitness Center, Duke Center For Living, Duke University, Duke University Health System and any of their trustees, officers, agents, and employees from every claim, liability, or demand of any kind, on account of any injuries to my person or property that I may sustain arising out of and/or participation in said activities. This waiver shall bind my heirs, my assigns, my personal representatives and myself.

_____

Member's Initials

WELCOME TO THE *DUKE HEALTH & FITNESS CENTER!*

MEMBERSHIP APPLICATION

Please complete the following information to help us better serve you

_____ _____ _____

Name: (Last) **(First)** **(MI)**

_____/_____/_____ _____ _____ **Height: _____ Weight: _____**

Birthdate **Age** **Gender**

_____ _____ _____

Daytime Phone Number **Evening Phone Number** **E-mail address**

_____

Mailing/Billing Address **City** **State** **Zip Code**

_____ _____

Primary Occupation **EmergencyContact** **Phone Number**

_____ _____ _____

Personal Physician **Office Phone/Fax #** **Date of Last Physical Exam**

How did you find out about the Duke Health & Fitness Center?

- ☐ Friend is a member
- ☐ Physician Referral
- ☐ Former Cardiac Rehab Client
- ☐ Duke employee
- ☐ Family/Spouse is a member
- ☐ Former Pulmonary Rehab Client
- ☐ Web Page
- ☐ Past Member
- ☐ Former Physical Therapy Patient
- ☐ Special Promotion, please specify _____
- ☐ Former Arthritis Client

Time you are most likely to exercise:

☐ **6 AM** ☐ **8 AM** ☐ **10 AM** ☐ **NOON** ☐ **2 PM** ☐ **5 PM**

What is your primary reason for joining the Duke Health & Fitness Center?

_____

_____

_____

_____

Please check any of the following activities you might be interested in:

Group Exercise Classes

_____Land Aerobics _____ Water Exercise Classes _____ Mind/Body Classes (yoga, pilates, etc.)

_____ Arthritis Pool Classes _____ Strength/Flexibility Classes _____ Indoor Cycling

_____ Cardiovascular Equipment _____ Strength Training _____ Other, please list: _____

Please check any of the following services you might be interested in (some at additional cost):

_____ Personal Training _____ Massage Therapy _____ Weight Loss Programming

_____ Nutrition Programming _____ Smoking Cessation _____ Stress Management Programming

_____ Physical Therapy _____ Arthritis Program _____ Health Psychology/Behavioral Counseling

PLEASE READ CAREFULLY BEFORE SIGNING:

I certify that all statements made on this application are accurate and that my answers to questions on the medical screening questionnaire are complete and true to the best of my knowledge. I understand that any misrepresentation or misinformation in this application/questionnaire could result in the rejection of my application, and could ultimately result in revocation of my membership. I understand that, based on my current symptoms or my medical condition, I may be required to have clearance from a physician, including a baseline medical examination and/or an exercise stress test or screening fitness test before my membership application can be accepted. I understand that additional costs may be incurred based upon services rendered. I authorize my personal physician and any other medical facility to release my medical records for review by appropriate staff at Duke Health & Fitness Center.

_____ _____/_____/_____

Member Signature **Date**

HEALTH HISTORY QUESTIONNAIRE

Read carefully and answer all questions.

YES NO

☐ ☐ Are you a male age 45 or older**, OR** are you a female age 55 or older?

☐ ☐ Have you ever regularly smoked cigarettes?

If yes, do you currently smoke cigarettes?

☐ YES Packs/day: _____ Years Smoked: _____

☐ NO Date Quit: _____ Packs/day: _____Years Smoked: _____

☐ ☐ Do you have, or have you EVER had High Blood Pressure (>140/90)

Are you taking medication for this? Yes No

Do you know your last blood pressure reading? Yes No BP: _____

☐ ☐ Do you have elevated blood sugar or diabetes? If yes, is your diabetes:

☐ well controlled

☐ not very well controlled

☐ not sure

Do you take insulin to control your diabetes? Yes No

Do you take a pill (oral agent) to control your diabetes? Yes No

Is your diabetes controlled by diet alone? Yes No

☐ ☐ Do you have high blood cholesterol (>200 mg/dl) or low HDL cholesterol (< 40 mg/dl)?

Are you taking medication for this? Yes No

Do you know your last cholesterol reading? Yes No

Total: _____ HDL: _____

☐ ☐ Has any member of your immediate family (parents, brothers, sisters) developed heart disease or had a stroke before age 55?

☐ ☐ Do you currently experience chest pain, or a numbness or ache in your left arm, jaw or neck at rest or during physical activity?

☐ ☐ Do you lose your balance because of dizziness or do you ever lose consciousness (faint)?

☐ ☐ Do you currently experience shortness of breath when performing daily activities or upon mild exertion, or wake up suddenly with shortness of breath?

☐ ☐ Have you ever had an exercise stress test? If yes, what year? _____

YES NO

☐ ☐ Are you a post menopausal female NOT currently on hormone replacement therapy?

☐ ☐ Do you have a family history of osteoporosis?

☐ ☐ Are you currently under a physician's care for an active or chronic medical condition?

Date of last visit: _____ Condition(s): _____

☐ ☐ Have your symptoms changed since your last appointment with your primary physician?

☐ ☐ Do you know of any reason why you should not do physical activity?

If yes, why? _____

☐ ☐ Has a physician ever told you that you have (or have had) **Heart Disease** (heart attack, surgery, heart murmur, irregular heart beats, angina, heart failure, etc.) OR **Vascular Disease**?

IF **YES**, please check which condition(s) you have (or have had):

YES NO

☐ ☐ Heart attack (when?_____)

☐ ☐ Coronary Artery Bypass Surgery (when? _____)

☐ ☐ Angioplasty (PTCA) or Stent placement (when? _____)

☐ ☐ Angina (chest pain/discomfort) If yes, how many episodes in a week?_____

How many SL Nitroglycerin pills do you take per week?_____

☐ ☐ Irregular Heart Beats

☐ ☐ Heart Failure (when? _____)

☐ ☐ Heart Murmur or valvular heart disease (what valve? _____)

☐ ☐ Heart Valve Surgery (what valve? _____) (when? _____)

☐ ☐ Pacemaker Implant (when? _____)

☐ ☐ AICD Implant (when? _____)

☐ ☐ Stroke or TIA (when?_____)

☐ ☐ Peripheral Vascular Disease

Have you ever been told by a physician that you have any of the following medical conditions:

YES NO

- ☐ ☐ Thyroid/Kidney/Liver Disease? (Circle) (when?_____)
- ☐ ☐ Bronchitis/Emphysema/Asthma or other Lung Disease (Circle)
- ☐ ☐ Ulcer/Colon Disorder (Circle) (when?_____)
- ☐ ☐ Cancer What type?_____ (when?_____) (current status?_____)
- ☐ ☐ Seizures (when?_____)
- ☐ ☐ Chronic or Severe Headaches (when?_____)
- ☐ ☐ Arthritis What type?_____ Joint(s) affected? _____
- ☐ ☐ Osteoporosis
- ☐ ☐ Chronic Orthopedic Problem Specify : _____ (when?_____)
- ☐ ☐ Major Injury Specify: _____ (when?_____)

If needed, use this space to further explain YES responses:

_____

_____

_____

Please list all <u>major</u> surgery you have had as well as any surgery in the past year (please include dates)

_____

_____

Please list all medications you are currently taking:

Medication Name	**Dose**	**Frequency**
example: tenormin	***25mg***	***3 times a day***

Allergies: _____

_____

Exercise:

- How would you describe your daily activity:

( ) Sitting most of day ( ) Light activity ( ) On feet 6-8 hrs/day ( ) Manual Labor 6-8 hrs/day

- Describe your current exercise routine:
  - Aerobic Activities: _____
  - Strenth/Resistance Activities: _____
  - Stretching/Flexibility Activities: _____

Nutrition:

- What is your present weight? _____lbs What is your present height? _____
- How long have you maintained your present weight? _____ yrs _____ months
- Are you satisfied with your current weight ? ( ) Yes ( ) No
- Ideally, what would you really like to weigh now? _____ lbs
- Do your daily food choices contribute to a healthy lifestyle? ( ) Yes ( ) No

Stress Management:

- Overall, how stressful is your life? (Circle One.)

  Very Stressful Moderately Stressful Mildly Stressful Not Stressful

- In which areas do you experience significant stress? Check all that apply.

☐ Employment-related stress ☐ Social/interpersonal concerns

☐ Family-related stress ☐ Financial worries

☐ Health-related stress ☐ Other (Please specify: _____)

- How effective are you with managing your stress? Check the one that best fits you now:

☐ Very effective (I've got stress under control.)

☐ Somewhat effective (I've got a handle on stress, but could benefit from more ideas or support in coping with it.)

☐ Ineffective (I need to learn some new ways to cope with stress.)

☐ Very ineffective (My stress is overwhelming and I need help coping now.)

Lifestyle Changes:

- How interested are you in making lifestyle changes in each of the following areas?

	Very Interested	Moderately Interested	Somewhat interested	Not very interested	Not at all interested
Exercising					
Losing Weight					
Changing my diet					
Managing Stress					
Quitting Smoking					
Improving Relationships					

- How likely is it that you will actually make changes in the following areas?

	Very Likely	Moderately Likely	Somewhat Likely	Not very Likely	Not at all Likely
Exercising					
Losing Weight					
Changing my diet					
Managing Stress					
Quitting Smoking					
Improving Relationships					

- How much control do you believe you have over the following?

	Complete	Very Much	Some	Not much	None
Exercising					
Losing Weight					
Changing my diet					
Managing Stress					
Quitting Smoking					
Improving Relationships					

Is there anything else you would like to tell us about yourself that would help us to assist you in making positive lifestyle changes at the Duke Health & Fitness Center?

_____

_____

_____

Duke Center for Living
DUKE UNIVERSITY HEALTH SYSTEM

DUKE CENTER FOR LIVING/DIET AND FITNESS CENTER

CLIENT/GUEST CODE OF CONDUCT

The staff of the Duke Center for Living/Diet and Fitness Center is committed to providing high quality patient care and a therapeutic environment to provide effective programming for all clients. We are dedicated to maintaining an environment in which each client can feel safe and respected. In order to assure a positive experience, clients are expected to conduct themselves in an appropriate manner at all times while participating in DCL/DFC programs. The following standards of conduct apply to all clients during their program participation as well as to all guests during their visit at either campus.

1. The client must conduct himself in an appropriate manner while in a program or within any facility on the DCL/DFC campus. Clients are expected to be respectful of other participants and staff.

2. Clients may not use profane, abusive or loud and boisterous language while on the premises or engage in any action, which may be discourteous or harmful to others.

3. Clients are required to interact appropriately with other clients, staff, guests, vendors and others while on the premises. Their behavior should in no way violate another person's sense of privacy or dignity.

4. Clients may not make threats, fight, or engage in any inappropriate or unwanted physical contact with another person while on the premises.

5. Clients suspected to be under the influence of alcohol or illegal drugs would not be allowed admission into any of the facilities.

6. Clients are encouraged to follow program goals and exhibit full participation in all appropriate program activities.

7. Clients are encouraged to respect the program goals of other participants by not encouraging activities contrary to program standards.

I have read the above Code of Conduct and agree to abide by these rules while participating in any DCL/DFC program. I understand that violations of any of these rules may result in disciplinary action or termination of my participation in any program.

_____ _____

Signature Date

Duke Center for Living
DUKE UNIVERSITY HEALTH SYSTEM

Requirement(s) for Physician's Clearance:

- MI, coronary revascularization, or sudden death before 55 years of age in father or other male first-degree relative, or before 65 years of age in mother or other female first-degree relative
- Current cigarette smoker or quit within the previous six months
- Systolic blood pressure of $\geq$ 140mm Hg or diastolic $\geq$ 90mmHg, confirmed by measurements on two separate occasions, or on antihypertensive medication
- Total serum cholesterol of >200mg/dL or high-density lipoprotein cholesterol of <35mg/dL, or on lipid-lowering medications. If low-density lipoprotein cholesterol is available, use >130 mg/dL rather than total cholesterol
- Fasting blood glucose of $\geq$110 mg/dL confirmed by measurements on at least 2 separate occasions.
- BMI of $\geq$ 30 kg/m^2 or waist girth of >100cm
- Not participating in regular exercise program or meeting the minimal physical activity recommendations from the U.S. Surgeon General's report

Requires Physician Clearance if:

- Male 45 years or older OR Female 55 years or older

AND

- One or more of the above risk factors

OR

- Two or more of the above risk factors

Physician's Statement and Clearance Form

On the Health History Questionnaire you just completed, you identified that you have one or more heart and/or other medical risk factors which may impair your ability to exercise safely. For this reason, you need to have a physician complete and return this medical clearance form before you can begin exercising at Duke Health & Fitness Center.

We recognize that you are eager to start your fitness program, and we sincerely regret any inconvenience that this may cause you. However, please keep in mind that we want your exercise experience at Duke Health & Fitness Center to be as safe as possible.

In order to expedite this process, we will gladly fax this form directly to the physician of your choice. If the doctor is aware of your medical history, he/she may be able to complete this form and fax it right back to us.

I hereby give my physician permission to release any pertinent medical information from any medical records to the staff at Duke Health & Fitness Center. All information will be kept confidential.

Patient signature_____ **Date**_____

Information requested for _____
Reason for medical clearance_____
Physicians name_____ Phone_____ Fax_____
Address_____

For Physician Use Only

Please check the appropriate following statements:

- ☐ I concur with my patient's participation with no restrictions.
- ☐ I concur with my patient's participation in any exercise program if he/she restricts activities to:

  _____

  _____
- ☐ I do not concur with my patient's participation in any exercise program (if checked, the individual will not be allowed to join Duke Health & Fitness Center.
  Reason_____
- ☐ It is my medical judgment that my patient requires an ETT prior to starting his/her exercise program.
  - o Please make an appointment for my patient at The Wallace Clinic, at The Center for Living.
  - o My office will make an appointment for my patient.

Physician's name (type or print)_____

Physician's signature_____ Date_____

Please return fax to: Membership Office at 919-681-7467

Duke Health & Fitness Center
DUKE UNIVERSITY HEALTH SYSTEM

Agreement and Release of Liability

1. In consideration of gaining membership or being allowed to participate in the activities and programs of the Duke Health & Fitness Center and to use its facilities, equipment, and machinery in addition to the payment of any fee or charge, I do hereby waive, release and forever discharge Duke Health & Fitness Center and its officers, agents, employees, representatives, executors, and all others from any and all responsibilities or liability for injuries or damages resulting from my participation in any activities or my use of equipment or machinery in the above-mentioned facilities or arising out of my participation in any activities at said facility. I do also hereby release all of those mentioned and any others acting upon their behalf from any responsibility or liability for any injury or damage to myself, arising out of or connected with my participation in any activities of the Duke Health & Fitness Center or the use of any equipment at Duke Health & Fitness Center.

2. I understand and am aware that strength, flexibility, and aerobic exercise, including the use of equipment, is a potentially hazardous activity. I also understand that fitness activities involve a risk of injury and even death and that I am voluntarily participating in these activities and using equipment and machinery with knowledge of the dangers involved. I hereby agree to expressly assume and accept any and all risks of injury or death.

3. I do hereby further declare myself to by physically sound and suffering from no condition, impairment, disease, infirmity, or other illness that would prevent my participation in any of the activities and programs of the Duke Health & Fitness Center or use of equipment or machinery except as hereinafter stated. I do hereby acknowledge that I have been informed of the need for a physician's approval for my participation in an exercise/fitness activity or in the use of exercise equipment and machinery. I also acknowledge that is has been recommended that I have a yearly or more frequent physical examination and consultation with my physician as to physical activity, exercise, and use of exercise and training equipment so that I might have recommendations concerning these fitness activities and equipment use. I acknowledge that I have either had a physical examination and have been given any physician's permission to participate, or that I have decided to participate in activity and/or use of equipment and machinery without the approval of my physician and do hereby assume all responsibility for my participation and activities, and utilization of equipment and machinery in my activities.

Date _____ Signature _____