DiSepio Institute for Rural Health and Wellness
Fitness Center
Staff Membership Application

Date:_____

New: ☐
Renewal: ☐

MEMBER INFORMATION

First name: _____ Last name:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone: __(___)_____ Work Phone:__(___)_____

Email:_____

Gender: (Circle One): Male Female Date of Birth: _____

Type of Membership (circle one): Employee Couple Family

If a spouse or sponsored dependent, please provide SFU employee name_____

Payment (circle one): Semester Monthly Payroll Deduction

EMERGENCY CONTACT

Name:_____

Relationship:_____

Phone: __(___)_____

MEDICAL HISTORY

Heart Trouble	Yes	No	High Blood Pressure	Yes	No
Palpitations	Yes	No	High Cholesterol	Yes	No
Lung Disease	Yes	No	Asthma	Yes	No
Chest Pain w/Exercise	Yes	No	Chest Pain at Rest	Yes	No
Heart Murmur	Yes	No	Abnormal EKG	Yes	No
Claudication	Yes	No	Dizzy Spells	Yes	No
Shortness of Breath	Yes	No	Lung Disease	Yes	No
Diabetes	Yes	No	Smoker	Yes	No
Joint Pain	Yes	No	Fainting	Yes	No
Swelling of ankles	Yes	No	Cancer	Yes	No
Seizures	Yes	No	Stroke	Yes	No

Are there any other medical conditions that we should be aware of that may prevent you from performing physical activity?_____

_____

_____

List any surgeries or hospitalizations that you have had:_____

_____

_____

DiSepio Institute for Rural Health and Wellness
Fitness Center
Medical History

First Name:_____ Last Name:_____

List any medications, vitamins, herbals, or supplements that you are currently taking:

_____
_____
_____
_____
_____

Does anyone in your immediate family (father, mother, sister, brother, aunt, uncle, or grandparent have a history of heart disease or artery disease?_____
_____
_____
_____

Are you currently participating in any type of physical activity? If so, what type of activity and how frequently do you participate?_____
_____
_____
_____
_____

Are there any other questions or concerns that you feel you should bring to the staff's attention prior to participating in any physical activity program?_____
_____
_____
_____
_____

I have read this questionnaire and have understood all of the components. I have answered all of the components to the best of my ability and knowledge.

Name:_____

Signature:_____

Date:_____

STAFF USE ONLY

Cleared to exercise_____ Not cleared to exercise_____

Reason_____

Staff signature_____ Date_____

The DiSepio Institute For Rural Health and Wellness
at Saint Francis University
Release and Waiver of Liability Form

HEALTH STATEMENT: In requesting permission to access or use the equipment at the DiSepio Institute for Rural Health and Wellness at Saint Francis University, I affirm that my general health is good and that I am not adversely affected by the exercise that I will undertake. I am not currently under the care of a physician who should be advised of my desire to participate in physical activity. If I am under the care of a physician, I affirm that I have received his/her permission to participate in physical activity at the DiSepio Institute.

AGREEMENT TO FOLLOW RULES AND POLICIES: I understand that the DiSepio Institute for Rural Health and Wellness at Saint Francis University provides both directed and self-directed programs. I understand that I may be provided a general overview of the equipment. Fitness instruction is available, upon request, by trained staff members. I agree to follow all rules and policies of the DiSepio Institute. I agree to abide by any reasonable requests concerning use of the facility as directed to me by the staff of the DiSepio Institute. I agree to operate and use the equipment only in the manner in which it was intended and designed to use, therefore following all written and verbal instructions provided by the staff at the DiSepio Institute. I understand that if I fail to abide by and follow instructions or requests by the staff, this may result in the termination of my privileges at the facility. I further understand that the staff at the DiSepio Institute has the right to terminate or alter my privileges at the facility at their discretion. Membership fees would not be refunded to individuals that have had their privileges terminated at the facility.

RELEASE AND WAIVER: I hereby accept all risks, known and unknown, to my health that are associated with my access to the DiSepio Institute for Rural Health and Wellness. I accept all risks to my health, risk of injury, or even death that may result from my participation in activities and exercise sessions at the facility. I release the facility for any and all claims and causes of action for loss of or damage to my property and for any and all illness or injury to my person, including my death, that may result or occur during my use of the facilities, whether caused by negligence of the DiSepio Institute, the University, its governing board, officers, employees, or representatives or otherwise. I agree to release and hold harmless the DiSepio Institute for Rural Health and Wellness at Saint Francis University and its employees from any and all liability whatsoever which may result from my use of the facility or the equipment. This statement shall serve as a release and hold harmless the DiSepio Institute for Rural Health and Wellness and its employees by my heirs, executors, administrators, if any and me.

I have carefully read this agreement and understand it to be a release and waiver of all claims and causes of action for my injury or death or damage to my property that occurs while using the DiSepio Institute for Rural Health and Wellness and it obligates me to indemnify the parties named for any liability for injury or death of any person and damage to property caused by my negligent or intentional act or omission.

Signature:_____ Date:_____

Name (please print):

_____

DISEPIO INSTITUTE FOR RURAL HEALTH AND WELLNESS
108 FRANCISCAN WAY
LORETTO, PA 15940

Acknowledgement of Receipt of Privacy Notice

Purpose of this Acknowledgement

This Acknowledgement, which allows the DiSepio Institute to use and/or disclosure personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by DiSepio Institute for Rural Health and Wellness (the "DiSepio Institute") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.

2. I am aware that the DiSepio Institute maintains a Privacy Notice which sets forth the types of uses and disclosures that the DiSepio Institute is permitted to make under the Privacy Regulations and sets forth in detail the way in which the DiSepio Institute will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.

3. I understand and acknowledge that in its Privacy Notice, the DiSepio Institute has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the DiSepio Institute at the following address:
108 FRANCISCAN WAY, LORETTO, PA 15940, Attention: Heather Meek, Saint Francis University/DiSepio Institute Compliance Officer.

4. I understand and acknowledge that I have the right to request that the DiSepio Institute restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the DiSepio Institute is not required to agree to restrictions requested by me, but if the DiSepio Institute agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

   I request the following restrictions be placed on the DiSepio Institute's use and/or disclosure of my health information (leave blank if no restrictions):

   _____

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT AND A COPY OF THE DISEPIO INSTITUTE'S POLICY NOTICE AND AGREE TO THE DISEPIO INSTITUTE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

_____ _____
Signature of Client or Representative Date

_____
Client's Name

_____
Date of Birth

_____
Social Security Number

_____ _____
Name of Personal Representative (if applicable) Relationship to Client

To Be Completed by the DiSepio Institute

The requested restrictions on the use and/or disclosure of the client's health information set forth above are:

_____ Accepted _____ Denied _____ Not Applicable

_____ Other (explain) _____

_____ _____
Signature of Authorized DiSepio Institute Representative Date