Membership Application

Member # _______________

Our Mission: To enable people with physical disability and chronic health conditions to lead healthy, active, and independent lifestyles through physical activity, sport, recreation, advocacy, policy, and research.

PERSONAL INFORMATION

Date (MM/DD/YYYY) _________________

First Name (Mr.☐/Mrs.☐/Ms.☐) _________________ Middle Initial ____ Last Name __________________

Date of Birth (MM/DD/YYYY) _____________ Age ___ Male☐ Female☐ Email ______________________

Address ___________________________ City ____________________ State ______ Zip Code __________

Home Phone _____________ County: ☐ Blount ☐ Jefferson ☐ Shelby ☐ St. Clair ☐ Walker ☐ Other

Employed by _________________________ Retired from __________________________ Not Employed ☐

Are you a Veteran? Yes ☐ No ☐ Branch of Service __________________

Dates of Service (MM/YYYY) ___________ - ___________

Emergency Contact (Name) __________________ Relation ____________ Daytime Phone ____________

Race/Ethnicity (Optional) ☐ Asian/Pacific Islander ☐ Black/African American ☐ Hispanic/Latino

☐ White/Caucasian ☐ Native American ☐ Other

Referred By ☐ Member ☐ Physician ☐ Staff Name: _____________________________

☐ Educator ☐ PT/Therapist ☐ Other

Qualifying Condition _________________________________

Treating Physician (Name) ____________________________ Phone ______________ Fax _____________

MEMBERSHIP FEES

☐ Individual $55/month

Additional Adult (ages 19 and older) who resides in your household $25/month

Additional Youth (ages 18 and under) who resides in your household $20/month

Enrollment Fee: $100 for the main member + $25 for each additional individual on the membership (please note that enrollment fees are non-refundable)

ADDITIONAL INDIVIDUALS ON THE MEMBERSHIP

Name _________________ Birth Date __________ Qualifying Condition (if applicable) _________________

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Name _________________ Birth Date __________ Qualifying Condition (if applicable) _________________

Please mark all interests:

☐ Fitness ☐ Aquatics ☐ Recreation ☐ Athletics ☐ Research ☐ Advocacy Initiatives

Please note that all applications are reviewed to ensure members meet eligibility requirements. Proof of residency for all members will be required.

MEMBERSHIP TERMS

A. **<u>DURATION OF MEMBERSHIP</u>**:
Lakeshore membership is continuous for a minimum of one year and not transferable or refundable after 30 days (see 'Member's Right To Cancel' section below). After one year, membership will automatically renew month to month after the first year.

B. **<u>MEMBER'S RIGHT TO CANCEL</u>**:
To cancel this membership, written notice of your intention to cancel must be delivered or mailed prior to the first of the month and you must bring your account balance to zero. Members agree to pay charges for goods, services and monthly dues, whether the facilities are used or not, until termination of membership. To cancel, a written notice must be delivered or mailed before midnight on the 30th day after your sign this contract (a re-enrollment fee of $100 will be required). Please mail cancellation notice to:

Lakeshore Foundation
Attention: Membership Accounting
4000 Ridgeway Drive
Birmingham, AL 35209

C. **<u>CANCELLATION OF MEMBERSHIP BY LAKESHORE FOUNDATION</u>**:
Lakeshore Foundation reserves the right to immediately terminate the membership of any member engaging in conduct in violation of this contract or the rules and regulations of Lakeshore Foundation.

D. **<u>MEDICAL CONDITIONS</u>**:
If you are unable to participate in programs for an extended period of time due to a medical condition, your membership may be placed in an inactive status after receipt of written documentation from your physician. There will be no re-enrollment fee to reactivate your membership.

E. **<u>CONTINUOUS MEMBERSHIP</u>**:
A re-enrollment fee of $100 must be paid to rejoin if membership is allowed to expire or if membership is cancelled. All necessary paper work will have to be resubmitted prior to re-enrolling.

PAST DUE ACCOUNTS / FEES

Membership must remain current to avoid cancellation and loss of privileges to the facility. A statement will be sent at thirty (30) days for outstanding fees. After sixty (60) days, memberships will be temporarily suspended until all fees are paid in full. After ninety (90) days, memberships will be cancelled. To rejoin at a later date, all past due fees must be paid as well as a $25 re-registration fee. (Note: Re-enrollment fee) A fee of $25 will be charged for insufficient funds or returned checks. A $5 fee will be charged for lost scan cards.

AUDIO/VISUAL CONSENT

I hereby consent and authorize the taking of photographs, movies, films, videotapes, tape recordings, or reproductions (collectively, "Reproductions") of the persons who are hereby applying for membership and consent to use, copyright, license, publication or broadcast of the same for advertising, educational, promotional, or publicity purposes on the part of Lakeshore Foundation and by its affiliated and associated organizations, including its directors, officers, agents, servants and employees. I hereby grant and assign to Lakeshore Foundation the right, title, and irrevocable authority and interest to such Reproductions. I waive any and all claims for compensation and waive any and all claims related to or arising out of the publication and dissemination of the same of any lawful purposes. I further authorize the communication of information concerning the undersigned in connection with the utilization of such Reproductions by Lakeshore Foundation and its affiliated or associated organizations, and their respective directors, trustees, officers, agents, servants and employees without claim for compensation and waive all claims related to or arising out of the publication and dissemination of the same.

______ *(initial)*

PROGRAM EVALUATION/RESEARCH

I hereby consent and authorize the use of information I provide for use in program evaluation and research where needed. I understand that my personal information will be kept confidential and, in no way, will my identity be revealed.

_____ (initial)

RELEASE AND INDEMINITY

I hereby agree that all use of Lakeshore Foundation's facilities, premises, programs and services including transportation shall be undertaken at my sole risk and Lakeshore Foundation shall not be liable for any injuries, accidents or deaths occurring to applicant, arising either directly or indirectly out of utilizing Lakeshore Foundation's facilities, services and programs, whether caused by the negligence or other wrongful conduct of Lakeshore and any of its agents or employees. The applicant for himself(herself) and on behalf of his(her) executors, administrators, heirs, and assigns, does hereby expressly release, discharge, waive, relinquish, and covenants not to sue Lakeshore Foundation, its officers and agents for all such claims, demands, injuries, damages or cause of action, with respect to use of Lakeshore Foundation facilities, premises, programs and services which the applicant may suffer or incur as a result of participation in such program, whether or not caused by the negligence or wrongful acts of such persons or any agents, servants or employees of any of them. I do further agree to indemnify and hold harmless each of them, of and from any and all claims, demands or actions of any kind or nature whatsoever arising out of any injury or damages incurred by the Applicant. In signing this release, I acknowledge and represent that I am over 19 years of age, I am of sound mind, I have read this release, understand it, and sign it voluntarily, and that this paper contains the entire agreement between myself and Lakeshore Foundation. The Applicant declares that he(she) is physically able to participate in physical activity. Further, Applicant declares that Lakeshore Foundation has advised him(her) to obtain a medical clearance if he(she) is unsure of his/her physical health.

_____ (initial)

MEMBERSHIP AGREEMENT

Below are the signatures of all persons applying for memberships who are at least 19 years of age, and signatures of guardians for all persons applying for membership who are less than 19 years of age. I HAVE READ AND AGREE WITH THE TERMS OF THIS CONTRACT, and any questions were answered to my full satisfaction. I will follow Lakeshore Foundation's rules and regulations, amended from time to time, and Lakeshore Foundation's failure timely to enforce, in whole or in part, its rights, privileges or powers under this contract shall not operate as a waiver thereof. I have received a copy of this contract.

____ Date ______________
Member or Parent / Guardian Signature (if member is under 19 years of age) (MM/DD/YYYY) *By using an electronic signature, you agree it is the legal equivalent of your manual signature on this agreement.*

____ Date ______________
(MM/DD/YYYY)

____ Date ______________
(MM/DD/YYYY)

____ Date ______________
(MM/DD/YYYY)

Family Member Signatures (all members 19 years of age or over)
By using an electronic signature, you agree it is the legal equivalent of your manual signature on this agreement.

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INTERNAL USE *(Only)*

Applicant enrolling for ______________________ Date ___________ LF Rep ______________________
(Type Membership)

Date of Enrollment (M/D/Y) ____________ Membership # _________________________

Membership valid from ___________ to ____________ at an annual fee of $ ________________

Physician Information

Lakeshore Foundation is dedicated to providing fitness and recreation opportunities to individuals with physical disabilities to assist them in living active, healthy lifestyles. In order to provide the most comprehensive fitness plan for each individual we request that a medical professional complete this form so that the staff at Lakeshore is aware of any goals, contraindications or recommendations you may have.

Individuals are not permitted to pursue an exercise program at Lakeshore Foundation until we receive this completed form from your office.

If you have any questions, please contact us at (205) 313-7400.

MD: ________________________________ DX. ___________________________

Patient Name: ____

Patient Phone #: ____

DOB (MM/DD/YYYY) __________________

I, ________________________________wish to begin or continue an exercise program at Lakeshore Foundation. **Please complete the following:**

Please list below any physical limitations or restrictions that might assist my instructors in designing an exercise program specific to my needs.

☐ I recommend that my patient become a participant in an exercise program with no restrictions

☐ I recommend that my patient become a participant in an exercise program **but urge caution** due to the following limitations / restrictions.

☐ I **do not** recommend that my patient participate in an exercise program.

Except as stated above, I am not aware of any consideration, which under ordinary circumstances would interfere with this patient performing moderate level physical activity. He/she may exercise at his/her own risk.

_________________________ M.D. _______________________ __________________

Physician Signature | Office Telephone Number | Date (MM/DD/YYYY)

Health History

Date (MM/DD/YYYY) ____________

Name (please print) ________________________________ DOB (MM/DD/YYYY) ____________________

Check any of the following that apply to your health (currently or in the past): The information you provide will help us develop an individualized plan to help you meet your fitness and recreation goals.

- ☐ Heart Condition - if yes specify ____________________________________
- ☐ High Blood Pressure or on Blood Pressure Medicine
- ☐ Cardiac Surgery - if yes, what kind and when ____________________________________
- ☐ Pain in your chest while DOING physical activity
- ☐ Pain in your chest while NOT DOING physical activity
- ☐ Diabetes Hypoglycemia (low blood sugar)
- ☐ Respiratory Disease (check all that apply)
- ☐ Chronic Bronchitis Asthma Emphysema
- ☐ Parkinson's Disease
- ☐ Multiple Sclerosis
- ☐ Stroke – when and how affected
- ☐ Arthritis (Type: ☐ Osteo ☐ Rheumatoid)
- ☐ Ankylosing Spondylitis
- ☐ Post-Polio Syndrome
- ☐ Muscular Dystrophy
- ☐ Ataxia
- ☐ Morbid Obesity
- ☐ Spinal Muscular Atrophy
- ☐ Neuropathy
- ☐ Lymphedema
- ☐ Osteogenesis Imperfecta
- ☐ Cerebral Palsy
- ☐ Spina Bifida
- ☐ Epilepsy or Seizure Disorder
- ☐ Head Injury date of onset ________________
- ☐ Shunt where______________ date _________
- ☐ Any other chronic medical condition ____________________________________
- ☐ Orthopedic Surgery – type and date ____________________________________
- ☐ Any bone or joint problems that limit you from engaging in physical activity – if yes specify ____________________________________
- ☐ Currently Pregnant
- ☐ Chronic Dizziness

- ☐ Amputation - Type _______________________
  Prosthesis ☐ Yes ☐ No
- ☐ Spinal cord injury (date of onset) ___________
  ☐ Paraplegia ☐ Quadriplegia
- ☐ Visual Impairment
- ☐ Requires assistance with community mobility
  ☐ Yes ☐ No

- ☐ Incontinence of bowel or bladder
- ☐ On a bowel management program
- ☐ History of gastrointestinal (GI) issues such as irritable bowel syndrome (IBS), C-diff, Crohn's, Colitis, etc.
- ☐ Current pressure sore(s)
  where ________________________________
- ☐ Current open wound(s)
  where ________________________________
- ☐ Seizure in the past 6 months
  date ____________________

Will a caregiver or family member be attending with you? ☐ Yes ☐ No

Do you use a walker, cane or wheelchair to get around inside the home or in the community? ☐ Yes ☐ No

List any information you would want shared with emergency personnel, including medications and allergies.

____

☐ New Member
☐ Current Member

Please choose one of these convenient payment options.

Name: ________________________________ Account # or Scan Card # ____________________________

Frequency of Payment:

I wish to pay my membership fees: ☐ Annually* ☐ Monthly
*may be paid by check

Donation to Lakeshore Foundation:

Yes, I would like to add $_____________to my membership fees each month to support scholarships for qualifying individuals to participate in Lakeshore Foundation programs.

Automatic Payment Authorization

This payment authority is to remain in full effect until 30 days after Lakeshore Foundation has received written notification from me (or either of us). I understand that termination of this agreement can only occur if all transactions are resolved and my membership account is in good standing. I understand that fees will be charged to (credit card), or debited from (debit card or bank draft) my account on the 2nd business day of the month. I agree to pay $25 for each occurrence of a failed transaction due to insufficient funds in my account.

Signature ____ Date ____________________

Method of Payment:

☐ Credit Card (Visa or MasterCard)
☐ Debit Card (Visa or MasterCard)
☐ Bank Draft from Checking or Savings Account (U.S. Banks only)

If choosing to pay by Credit or Debit Card, please provide the information requested.

Card Number ______________________________ Expiration Date (MM/YY) _____________

Name as it appears on card ____

If choosing to pay by **Bank Draft**, please provide the information requested.*

I (we) hereby authorize Lakeshore Foundation to initiate debit entries to my (our)

☐ Checking Account ☐ Savings Account (choose one)

at the depository financial institution named below and debit the same to such account(s).

Bank Name ____

Routing No. _____________________________ Account No._____________________________

(the 9 digits between the : I symbols on the bottom left of your check)

Name(s) on Account ____

Please provide a voided check.