



Membership Application

Member # _____

PERSONAL INFORMATION

Date (MM/DD/YYYY) _____

First Name (Mr. /Mrs. /Ms.) _____ Middle Initial ____ Last Name _____

Date of Birth (MM/DD/YYYY) _____ Age _____ Male Female

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

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
- Insurance Based Membership (Silver Sneakers and RenewActive)
- 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) _____

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

Name: _____

A. **DURATION OF MEMBERSHIP:**

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. **MEMBER'S RIGHT TO CANCEL:**

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. **CANCELLATION OF MEMBERSHIP BY LAKESHORE FOUNDATION:**

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. **MEDICAL CONDITIONS:**

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. **CONTINUOUS MEMBERSHIP:**

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.

RELEASE AND INDEMNITY

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)

PAST DUE ACCOUNTS / FEES

Name: _____

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)

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.

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

Date _____
(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)

By using an electronic signature, you agree it is the legal equivalent of your manual signature on this agreement.

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.

Date _____
(MM/DD/YYYY)

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.

Physician Signature M.D. _____ 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.

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

- | | |
|--|--|
| <input type="checkbox"/> Amputation - Type _____
Prosthesis <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Visual Impairment |
| <input type="checkbox"/> Spinal cord injury (date of onset) _____
<input type="checkbox"/> Paraplegia <input type="checkbox"/> Quadriplegia | <input type="checkbox"/> Requires assistance with community mobility
<input type="checkbox"/> Yes <input type="checkbox"/> No |

- | | |
|---|---|
| <input type="checkbox"/> Incontinence of bowel or bladder | <input type="checkbox"/> Current pressure sore(s)
where _____ |
| <input type="checkbox"/> On a bowel management program | <input type="checkbox"/> Current open wound(s)
where _____ |
| <input type="checkbox"/> History of gastrointestinal (GI) issues such as irritable bowel syndrome (IBS), C-diff, Crohn's, Colitis, etc. | <input type="checkbox"/> 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: _____

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.

Method of Payment:

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

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 _____

****Please provide a voided check.***