UF Living Well
College of Health and Human Performance
UNIVERSITY of FLORIDA

UF *Living Well* Program
MEMBERSHIP APPLICATION

Today's Date: _______________

Please print the following information and return it along with a check, money order, or payroll deduction form (available at ***Living Well***) to ***Living Well***, Room 12 Yon Hall, PO Box 118204, Gainesville, FL 32611-8204. Payment will be processed upon the completion of your two-week trial. There is a No Refund Policy for all memberships. You will be contacted to schedule your first workout orientation. If you have any questions, please call 392-9767.

UFID # _______-_______

Title: (circle one) Dr. Mr. Mrs. Ms.

Name: ____
Last First MI

E-Mail Address: ____________________________________

Campus PO Box: ______________________________ Campus Building & Room: ____________________

Home Address: ____
Street Address City Zip

Home Phone: ______________________ Work Phone: ______________________ Ext. ___________

Birthday: ________________________ Age: __________ Gender: M F

Height: _____________(inches) Weight _____________(lbs.) Desired Weight: _____________(lbs.)

Physician: _____________________________ Phone: ________________ Fax: ________________

Address: ____

Membership Type:
- ☐ New
- ☐ Renew

- ☐ Annual Membership $320.25
- ☐ Semi-Annual Membership $186.81
- ☐ One-Month Membership $ 37.36

Please tell us how you learned about ***Living Well***.
- ☐ Newsletter (name) ________________________
- ☐ Telephone Call
- ☐ Friend/Co-Worker (name) ___________________
- ☐ Radio
- ☐ Independent Alligator
- ☐ Other (specify) ____________________________

Occupation:
(please check all that apply)
- ☐ Faculty
- ☐ TEAMS
- ☐ USPS
- ☐ OPS
- ☐ Shands
- ☐ UAA
- ☐ Foundation
- ☐ Spouse
- ☐ Retired Employee
- ☐ Retired Spouse
- ☐ Other:

Membership Payment Method:
- ☐ Payroll Deduction
- ☐ Check: Receipt # _________________
- ☐ Money Order: Receipt # ____________

Checking a box here does NOT sign you up for your membership. Please see a staff member to finalize your membership.

In case of emergency contact: _____________________________________ Phone: ____________________

As a ***Living Well*** member, I agree to abide by all current ***Living Well*** policies and procedures as approved by the Advisory Board.

Applicant Signature: ____ Date: _______________ (Rev. 11/15/2005)

UF *Living Well* Program

PRE-PARTICIPATION QUESTIONNAIRE (PPQ)

In order to provide a more effective and safer exercise program, the *Living Well* Program recommends that you accurately and honestly complete this form. Any information you provide is done so VOLUNTARILY. Refusal to complete this form will in no way influence you eligibility for membership.

Last Name: ___________________________ First Name: ___________________________

Campus Phone: _____________________ Age: _____ Gender: Male ( ) Female ( )

Please check ( ) your response to the following questions: If yes, please explain.

Yes	No	Question
( )	( )	1. Are you currently taking any prescribed or over-the-counter medications? List the medication and its purpose. ________________________________
( )	( )	a. Are any of these a beta blocker, heart, or stroke medication? ________________
( )	( )	2. Has a physician ever told you that you have a heart condition? Explain ____________ ____
( )	( )	3. Do you feel pain or pressure in your chest, neck, shoulder(s) or arm(s) during or after physical activity?
( )	( )	4. Do you lose your balance because of dizziness or do you ever lose consciousness?
( )	( )	5. Has a physician ever told you or are you aware that you have high blood pressure?
( )	( )	6. Has anyone in your immediate family (parents, brothers, sisters) had a heart attack, stroke, or cardiovascular disease before age 50? Explain ______________________
( )	( )	7. Has a physician ever told you or are you aware that you have a high cholesterol level?
( )	( )	8. Do you currently smoke?
( )	( )	9. Do you have any bone or joint problems that could be made worse by a change in your physical activity? Explain ________________________________
( )	( )	10. Do you have any physical or medical conditions (e.g. diabetes, recent surgery, arthritis, pregnancy, etc.) not mentioned above, or do you know of any other reason why you should not engage in physical activity? Explain ________________________ ____
( )	( )	11. Are you currently exercising LESS than 3 times per week. If no, please list your activities. ________________________________

The fact that you answered **NO** to an above question does not guarantee that you will not have an abnormal response to exercise. All physical activity entails some risk. Always seek *Living Well* staff assistance if you experience chest or neck pain, radiating pain on one side or down one arm, severe headache, extreme fatigue, or any other unusual symptoms. These are abnormal response to exercise.

If you answered **YES** to a question in the shaded areas, it may be recommended that you obtain you physician's permission to participate. Your file will be reviewed, please help by being specific with your answers.

If you answered **YES** to any other question above, it will be recommended that you obtain your physician's permission before participation in a *Living Well* exercise program or fitness assessment. Please request a *Living Well* Physician's Permission form for completion.

_________________________________ ______________________ ________________

Signature (required) Home Phone Date

The *Living Well* Program recommends that everyone consult his or her physician before beginning any exercise program, after a lengthy period of inactivity, and/or if your health status changes.

For Staff Use Only
BP ___________
HR ___________
Date ___________
Initials ___________

For Staff Use Only
Physician Perm. Required?
Yes ☐ No ☐
Date ___________ Initials _____

The University of Florida
Living Well Program

College of Health and Human Performance
PO Box 118204
Gainesville FL 32611-8204
(352) 392-9767

I, (print name)________________________________, hereby consent to voluntarily participate in the ***Living Well*** Program and its associated activities and programs. I acknowledge that ***Living Well*** personnel have advised me of possible risks and complications that may result from my participation in the ***Living Well*** Program. These possible risks and complications may be related to my participation in resistive, aerobic and activities related to the safe performance of this exercise training and/or the assessment of the health-related components of physical fitness. There exists a remote possibility of adverse changes occurring during exercise, including, but not limited to: abnormal blood pressure, fainting, disorders of heart rhythm, and very rare instances of heart attack or even death; the possibility of stroke or other cerebrovascular incident or occurrence; mental, physiological, motor, visual, or hearing injuries; deficiencies, difficulties, or disturbances; partial or total paralysis; slips, falls, or other unintended loss of balance or bodily movement that may cause muscular, neurological, orthopedic, or other bodily injury, as well as a variety of other possible occurrences, any one of which could conceivably, however remotely, cause bodily injury, impairment, disability, or death. Any procedure such as this one carries with it some risk, however unlikely or remote.

I acknowledge that ***Living Well*** personnel are not medical doctors, and may not be licensed, certified, or registered instructors or professionals. I further understand that ***Living Well*** personnel will not provide medical advice; and I agree not to rely on any statements by them as medical advice. I have had an opportunity to discuss my participation in the ***Living Well*** Program with my own personal physician.

As part of my voluntary participation with the University employee wellness program, ***Living Well***, I give my permission for some of the program results to be used for group data analysis for program evaluation, research, and possible publication, now or in the future. Information and data will be reported only as part of a group. All reasonable precautions will be taken to protect the confidentiality of this information. All ***Living Well*** personnel are required to sign a “Statement of Confidentiality” to this effect. There are no anticipated benefits or compensation for participation.

As a voluntary participant in a research activity with the ***Living Well*** Program, I may inquire further about any of the procedures described to me. I may withdraw my consent and discontinue participation with the project or activity, at any time without prejudice, by informing the program director, Ms. Danielle Bean, at PO Box 118204, University of Florida, telephone number (352) 392-9767 that I wish to withdraw my permission to use collected group data.

I have read the procedure(s) described above. Questions or concerns about your rights as a research participant may be directed to the UFIRB Office, PO Box 112250, University of Florida, 392-0433.

______________________________	____________	______________________________
Program Participant	Date	Witness

Protocol #2001.319