THE WELLNESS CENTER
A MEMBER OF THE GREENWOOD LEFLORE HOSPITAL NETWORK
1802 Strong Avenue • Greenwood, MS 38930 • 662.459.2599 • www.glh.org/wellness

MEMBERSHIP APPLICATION (Yearly Contract)

1. _____
First Name MI Last Name

_____
Date of Birth Gender

_____
Mailing Address

_____
City State ZIP

_____
Home Phone Cell Phone

_____
Emergency Contact Relationship

_____
Emergency Contact Phone Number(s)

_____
Employer Phone Number

_____
Physician's Name Phone Number

2. _____
First Name MI Last Name

_____
Date of Birth Gender

3. _____
First Name MI Last Name

_____
Date of Birth Gender

4. _____
First Name MI Last Name

_____
Date of Birth Gender

5. _____
First Name MI Last Name

_____
Date of Birth Gender

Medical History	1	2	3	4	5
Heart Disease					
Enlarged Heart					
Heart Attack					
Chest Pain					
Heart Murmur					
Pacemaker					
High Blood Pressure					
Seizures					
Frequent Dizziness					
Asthma/ Shortness of Breath					
Diabetes					
Tumor					
Blood Clots					
Anemia					
Cancer					

Please indicate any related medical history for primary applicant and additional applicants by marking "X" under the designated member's medical history. (Primary Applicant = 1; Additional Members = 2, 3, 4 or 5)

NOTICE: Applicants age 45+ or recent medical conditions, please have your physician sign below for wellness clearance.

Physician Comments or Recommendations: _____
_____
_____
_____
_____
_____
_____

Physician Name: _____
Physician Signature: _____
_____
Date of Consent for Clearance: _____

PLEASE READ BEFORE SIGNING BELOW

I release and forever discharge the Greenwood Leflore Hospital Wellness Center and the employees or representatives of this facility from any and all liability, claims, costs, and expenses resulting from any injury or loss that I sustain in connection with my use of the services, facilities and equipment in Greenwood Leflore Hospital Wellness Center and any damage to myself or property caused by other users of the program and/or facilities. If I am a parent, I agree that my children or other minors under my control and supervision will obey all rules and regulations established by Greenwood Leflore Hospital Wellness Center at all times. I am aware that this Release of Liability is a contract between Greenwood Leflore Hospital Wellness Center and myself (and any additional members) and I sign it on my own free will and acknowledge that I have thoroughly read, understood, and agree to the terms and conditions of this membership agreement and all regulations and policies therein contained.

1. Primary Member Signature: _____ DATE: _____
2. Member Signature: _____ DATE: _____
3. Member Signature: _____ DATE: _____
4. Member Signature: _____ DATE: _____
5. Member Signature: _____ DATE: _____

STAFF SIGNATURE: _____ DATE: _____

MEMBERSHIP

- ☐ Individual - $29
- ☐ Family (2 - Spouse/Child) - $49
- ☐ Additional Family Members - $10
- ☐ Employee - $12
- ☐ Employee (with non-employee spouse) - $29
- ☐ Employee Family Members - $10 (household dependent)
- ☐ Swim-Ex (member) - $10
- ☐ Corporate I - $24
- ☐ Corporate II - $20
- ☐ Senior (65+) - $20
- ☐ Guest - $5 per day
- ☐ Locker Rental - $5
- ☐ Swim-Ex (nonmember) - $30

PAYMENT

- ☐ Bank Draft – Monthly on the 15th *(Need Voided Check)*
- ☐ Credit Card – Annual Only
- ☐ Paid in Full – Check or Cash

CHECKING ACCOUNT INFORMATION

_____
Bank Name

_____
City/State Phone Number

_____
Routing Number Account Number

CREDIT CARD ACCOUNT INFORMATION

☐ Visa ☐ Mastercard
☐ Discover ☐ American Express

_____
Account Number

_____
Expiration Date Security Code

I hereby authorize Greenwood Leflore Hospital Wellness Center to initiate debit from my payment account listed above in the amount of the membership monthly(15th)/annually I have chosen in my membership package selected. I acknowledge that I have thoroughly read, understood and agree to the terms and conditions of this membership agreement and all fees, regulations and policies therein contained. This membership is non-transferrable and there is no refund or cancellation of this membership irrespective of the amount of time spent by myself or others in actual use of the facilities, unless primary member experiences death, disabling injury or illness or relocates primary residence more than 25 miles from our facility. Default in payment shall result in the option of Greenwood Leflore Hospital's Wellness Center to be paid balance in full under this contract and any outside methods to enforce payments will be included, such as attorney/collections fees. All payments that are late will be subjected to a $10 late fee.

This contract will AUTO-RENEW on a YEARLY basis, unless you have submitted a written statement of cancellation 30 days in advance and delivered to our facility.

Monthly Membership Fee: $_____

MEMBER SIGNATURE: _____ DATE: _____

**If another party is paying for this membership, bank draft authorization signature is REQUIRED.*

PRINT NAME: _____

PAYER SIGNATURE: _____ DATE: _____

For Office Use Only: STAFF SIGNATURE: _____ *DATE:* _____

Attach voided check.

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Payroll Deduction Authorization

TO: Greenwood Leflore Hospital

You are authorized to deduct from my wages $ _____ each month until my membership is terminated.

You are further authorized to withhold such amount as may be necessary from the wages due me at the time I leave the employ of Greenwood Leflore Hospital to pay for any amount owing by me to the Greenwood Leflore Hospital, as evidenced by a note or by an open account.

MembershipType:_____StartDate:_____

Witness: _____

Print Name (Employee): _____

Amount: _____

Signature (Employee): _____

Employee Number: _____