ACTIVE COMMUNITY WELLNESS

2010 MEMBERSHIP FORM

GENERAL INFORMATION

Today's Date:		
Membership Type (check box) ☐ Seasonal ☐ Two Seasons ☐ Annual ☐ Lifetime		
Optional Donation: $_____ Thank you! Please see back page for donation instructions.		
Name:		
Date of birth:		Phone:
Street address:		
City:	State:	ZIP Code:
E-mail		

OPTIONAL INFORMATION

Current employer:		
Employer address:		How long?
Phone:	E-mail:	
City:	State:	ZIP Code:
Position:		

EMERGENCY CONTACT

Name of emergency contact:		
Phone:		Alt Phone:
City:	State:	ZIP Code:
Relationship:		

WOULD YOU LIKE TO REFER A FRIEND OR TWO?

Name	Address	Phone

WHAT IS YOUR WELLNESS GOAL?

SIGNATURE

I have read and agree to the waiver of liability on the following page. I agree there are no refunds.	
Signature of applicant:	Date:
Print Name:	

WAIVER OF LIABILITY FOR MEMBERS AND VOLUNTEERS

Active Community Wellness (ACW) welcomes people of all socioeconomic backgrounds. ACW makes every effort to ensure that no person, especially youth will be denied access to programs because of financial hardship.

Member/Volunteer Health:
The applicant represents that he/she is in physically sound condition and understands that participation in group exercise and other exercise, weight training, recreational sports, and use of pools, spas, saunas, steam rooms and fitness equipment
carry a potential risk of injuries or illness. The applicant further understands that ACW assumes no responsibility for any such injury or illness.

Member/Volunteer Conduct:
The applicant(s) agrees to abide by all policies and procedures of ACW and its programs; and understands that failure to act in accordance with these rules may result in expulsion from ACW membership.

Registered Sex Offenders (Levels 2 or 3) may not apply to become ACW members.
Is any applicant a Registered Sex Offender (Levels 2 or 3)? ___ No ___ Yes

Property Loss:
The applicant(s) understands that ACW is not responsible for personal property lost, damaged or stolen while using the ACW programs services, including parking lots.

Photograph and Video Permission:
The applicant(s) hereby gives permission for ACW to use, without limitation or obligation, photographs, film footage or tape recordings which may include the applicant(s) image or voice for purposes of promoting or interpreting ACW programs.

Insurance:
The applicant(s) understands that ACW does not provide any accident or health insurance for its members, participants and volunteers, and further understands it is the applicant's responsibility to provide such coverage if needed.

Medical Treatment:
The applicant(s) gives permission for ACW staff or volunteers to provide emergency medical treatment, and to transport to an emergency center for treatment. Also, the applicant(s) consents to medical treatment deemed immediately necessary or advisable by a physician.

Release of Liability:
I am an adult age 18 or older and wish to participate in ACW activities. In addition, if applicable, I give permission for my dependents to participate in ACW activities. I understand that accidents can sometimes happen. Therefore, in exchange for ACW allowing me, and if applicable, my spouse and my dependents to participate in ACW activities, I understand and expressly acknowledge that I release ACW, its employees, its boards, members, volunteers or guests from all liability for any injury, loss or damage connected in any way whatsoever to participation in ACW activities whether on or off the ACW premises. I understand that this release includes any claims based on negligence, action or inaction of ACW, its employees, boards, members, volunteers or guests.

Active Community Wellness, Inc.
PO Box 7621, Boise ID 83707

activecommunitywellness.org
(208) 639-1434

ACTIVE COMMUNITY WELLNESS

Donation Form

501(c)(3) EIN 26-3165602

Donor Information

Date of Donation	
Name	
Company	
Address	
City State Zip	
Telephone	
E-Mail	

Donation Information

I (we) donate a total of $_____ to be paid: ____now ____monthly ____quarterly ____yearly.

I (we) plan to make this contribution in the form of: ____cash ____check ____credit card ____

For your convenience, you may use the secure PayPal link at www.activecommunitywellness.org

Credit card, circle one	VISA MasterCard DISCOVER
Credit card number	
Credit card 3-digit code	
Expiration date	
Authorized signature	

Option

Our gift will be matched by _____ (company/family/foundation).

Anonymity

____ I (we) wish to have our gift remain anonymous.

Additional Information

What additional information would you like to include?

Please make checks, corporate matches, or other gifts payable to:

Active Community Wellness
PO Box 7621
Boise, ID 83707

Thank you!