1600 Medical Center Drive, Huntington, WV
304-691-1600

402 Thundering Herd Dr., Huntington, WV
304-696-4REC (4732) Fax: 304-696-4104

REQUEST TO PARTICIPATE IN MARSHALL HEALTH FITNESS PROGRAM

NAME: ______________________________ DOB:__________ 901#:____________

ADDRESS:______________________________PHONE #:______________GENDER: M or F

EMERGENCY CONTACT NAME/PHONE #:____

I do hereby request to participate in the Marshall Health Employee Wellness Program located at the Marshall University Recreation "REC" Center. I understand that only MU/MH employees and their covered dependents who have elected Marshall Health as their Medical Home through PEIA are eligible and that by participating in this program I should expect and will be required to do in the following:

- To have a fitness program tailored to my health needs.
- Within six (6) weeks of joining the program, to have an introductory, one-on-one, Personal Training session with an initial fitness assessment conducted by Campus Recreation staff.
- To schedule and participate in quarterly fitness assessments thereafter conducted by the Campus Recreation staff.
- To participate in biometric screening conducted by Campus Recreation staff.
- To be required by my Primary Care Physician to have my cholesterol, blood pressure, glucose levels and other health related information regularly checked and submitted to my Primary Care Physician.
- To be required to participate in individual or group activity at the Rec Center a minimum of 4 times in a three month period.
- To purchase a one year primary membership to the Rec Center with an out of pocket cost of $300 per year ($25.00 per month) (unsupported amount is $456). My dependents/significant other/spouse, as defined by Rec Center, may join at the same $300 rate ($25.00 per month) as a secondary membership.
- To abide by all other terms of the Marshall Recreation Center membership agreement.

I further understand that should I fail or refuse to fulfill the above conditions that my participation in the Marshall Health Employee Wellness Program may be terminated and my membership fee rate will be increased to the regular employee rate in effect at the time of the termination.

Patient's Consent and Authorization

I understand participation in this program may result in an exchange of medical information relevant to my activity at the Rec Center. Therefore, I consent to and authorize University Physicians & Surgeons, Inc. d/b/a Marshall Health to release to and exchange with the Marshall Recreation Center, health information concerning my ability to participate in the Marshall Health Employee Wellness Program. I understand this consent is revocable except to the extent action has already been taken. Authorization is not valid beyond one year from date of signature. Further disclosure or release of my health information is prohibited without specific written consent of person to whom it pertains.

Assumption of Risk, Waiver, and Release from Liability

I do hereby release, waive, indemnify and hold University Physicians and Surgeons, Inc. d/b/a Marshall Health and all their officers, trustees, directors, employees, and agents harmless from any claims, causes of action, suits, liability, losses, or damages for any property damage, property loss or theft, personal injury, death or other loss arising from or relating to the undersigned's use of the property, facilities, and/or services of the Marshall Recreation Center.

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Patient Signature Date

TO BE COMPLETED BY PRIMARY CARE PHYSICIAN

Physician's Name: (Please Print) ________________________________

Physician's Address & Phone Number: ________________________________

Exercise/ActivityRecommendations:________________________________

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( ) I recommend that this individual participate without limitation.

( ) I recommend that this individual participate with the following limitations/considerations:________________

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Primary Care Physician Signature: ______________________________ Date:____________

THIS FORM MUST BE PRESENTED TO MARSHALL REC CENTER TO PARTICIPATE