

NEW MEMBER ENROLLMENT INFORMATION

Please fill out **ALL** information. Please **PRINT!**
Cannot process membership without this information

Today's Date	
Name (Last, First, Middle)	
Date of Birth (M/D/Y)	
Member ID # (any 6-7 digit # for computer check-in)	6 required – 7th optional NUMBERS ONLY
Sex	
Age	
Home Address (Street)	
Address (City, State, Zip)	
Home Phone Number	
Work Phone Number	
E-mail Address	

- STAFF USE ONLY -

Date received: _____/_____/_____

Desk staff - please initial
*Entered into Prospect Tracking _____
*POS Health assessment fee _____

PAYMENTS:
*Enrollment fee
__cash
__ Visa __MC
__check # _____

*Membership fee
__cash
__ Visa __MC
__check # _____
\$ _____

Member Type (*check one*) and fill out information in that section

	Benefit-Eligible OU Employee (Group I, II, or IV) OU Employee ID# _____ (SIX digit number starting with 1_____.NOT starting with "P") Classification: __Administration __Classified __Faculty __AFSCME __FOP OU Department: _____ OU Bldg: _____ Room # _____
	Non-Benefit Eligible OU Employee (Group III) OU Employee ID# _____ (SIX digit number starting with 1_____.NOT starting with "P") Classification: __Administration __Classified __Faculty __AFSCME __FOP OU Department: _____ OU Bldg: _____ Room # _____
	Retired OU Employee (MUST receive OU retirement benefits)
	Spouse of OU Employee / Spouse of OU Retiree OU Employee's name: _____ Dept.: _____
	Dependent of OU Employee (MUST be on OU Employee's insurance plan to qualify) OU Employee's name: _____ Dept.: _____
	OU ROTC (Do not have to do a health assessment if you provide a copy of your current ROTC physical.)
	Community (Athens/local area resident who is not an OU Employee/Retiree/Spouse/Dependent or a full-time OU student)
	__ Grad Student __ Spouse of grad student: Grad student's name: _____
	Americorps – OU (must work for an OU Dept.) Please name dept: _____
	OU Innovation Center - business affiliate only/employee only
	Corporate Membership _____ <i>Name of business w/corporate membership</i> If SPOUSE, must provide corporate EMPLOYEE name: _____ *Corporate Membership includes EMPLOYEES only. **Corporate GOLD Membership includes EMPLOYEE, SPOUSES, and DEPENDENTS.

MEDICAL HISTORY

Assess your health status by marking all **true** statements below:

HISTORY

You have had:

- a heart attack
- heart surgery
- cardiac catheterization
- coronary angioplasty (PTCA)
- pacemaker/implantable cardiac
- defibrillator/rhythm disturbance
- heart valve disease
- heart failure
- heart transplantation
- congenital heart disease

SYMPTOMS

- You experience chest discomfort with exertion.
- You experience unreasonable breathlessness.
- You experience dizziness, fainting, or blackouts.
- You take heart medications.

OTHER HEALTH ISSUES

- You have diabetes.
- You have asthma or lung disease.
- You have burning or cramping sensation in your lower legs when walking short distances.
- You have musculoskeletal problems that limit your physical activity.
- You have concerns about the safety of exercise.
- You take prescription medication(s).
- You are pregnant.

NOTICE:

If your health status changes while you are a WellWorks member, you must contact Tom Murray or Erica Baker, coordinators of clinical exercise physiology. They will help you determine appropriate changes for your exercise program.

Please list **all** medications you are currently taking:

CARDIOVASCULAR RISK FACTORS

- You are a man older than 45 years.
- You are a women older than 55 years, have had a hysterectomy, or are postmenopausal.
- You smoke, or quit smoking within the previous 6 months.
- Your blood pressure is greater than 140/90 mm Hg **OR** you take blood pressure medication.
- You do not know your blood pressure.
- Your blood cholesterol level is greater than 200 mg/dL **OR** you take medication for you cholesterol
- You do not know your cholesterol level.
- You have a close blood relative who had a heart attack or heart surgery before age 55 (father or brother) or age 65 (mother or sister)
- You are physically inactive (i.e., you get less than 30 minutes of physical activity on at least 3 days per week).
- You are greater than 20 pounds overweight.

STAFF USE ONLY

Risk Factor Stratification: (Check all that apply.)

- | | | | |
|----------------------------------|---|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Age | <input type="checkbox"/> Impaired Fasting Glucose | <input type="checkbox"/> Family Hx | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Smoking | <input type="checkbox"/> Sedentary Lifestyle | <input type="checkbox"/> Dyslipidemia | <input type="checkbox"/> Hypertension |

Risk For CVD: (Circle one.)

HIGH MOD LOW

Exercise History

Do you presently engage in physical activity? No Yes:

If YES: What kind? _____ How often? _____

How far do you walk each day? 1-2 miles 3-4 miles More: _____

Is your occupation: Sedentary Active Occupation: _____

Exercise Goals

Please write down three wellness goals you would like to accomplish. Be as specific as possible.

Please tell us...

How did you find out about the WellWorks program? Did someone refer you, and if so, who?

WAIVER AND RELEASE

I desire to voluntarily participate in Ohio University's WellWorks program. I understand that during my fitness assessment and in participation of WellWorks activities, that certain dangers exist, such as fainting, abnormal blood pressures, dizziness, and in very rare instances, heart attacks. More common injuries include soft tissue injuries--e.g. sore muscles, tendinitis. Every effort will be made to minimize these conditions through the preliminary examination and by observations during admission. Should there be any reason to question my health or ability to safely participate in WellWorks, I assume full responsibility in obtaining the advice of my physician.

In consideration of my entry into this program, I, my heirs, executor, administrators, and assigns do hereby release and discharge Ohio University, its officers, agents, sponsors, or employees from any responsibility or liability for any subsequent exercise or other activities that I may engage in as the result of attending this program. I understand that any abnormal results will be sent to the following named physician, _____, for appropriate follow-up. I attest that I have full knowledge of any and all risks involved in participating in the WellWorks program. I further give permission for Ohio University to use data collected during the program. I understand these data will only be reported in a confidential and anonymous manner.

Signature: _____ Date: _____

OU Employees only:

BUREAU OF WORKERS' COMPENSATION INDUSTRIAL COMMISSION OF OHIO

Waiver of Workers' Compensation Benefits for a voluntary participant in an employer's sponsored recreation or fitness program/activity.

This waiver is being completed pursuant to section 4123.01 (C)(3) of the Revised Code, effective August 22, 1986. **Employer:**
Ohio University

The employer and employee shall list below those sponsored recreation or fitness activities for which the employee wishes to waive his or her rights to compensation or benefits under Chapter 4123 of the Revised code prior to engaging in those activities. Any sponsored recreation or fitness program not listed below may be eligible for Workers' Compensation benefits consideration should any injury occur.

Activities: Well Works, Ohio University's Wellness and Health Promotion Program. All activities that Well Works may have to offer or any sponsored Well Works event.

The undersigned declares that he or she is a voluntary participant in the employer's sponsored recreation or fitness activity/activities listed above and hereby waives and relinquishes all rights to Workers' Compensation benefits under Chapter 4123 of the Revised Code for any injury or disability incurred while participating on an annual basis on the listed activity/activities.

This form must be signed and dated by the employee. The employee will be provided a copy of the signed form, if requested.

Employee's Name (Print): _____ O/C 0161 (8.86)
Employee's Signature: _____ Date: _____

***Membership cannot be authorized until this form is completed and returned to WellWorks.**

STAFF USE ONLY:

Date Cleared: _____ **Initials:** _____

Comments:
