

REJOIN INFORMATION

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

Name (Last, First, Middle)	
Date of Birth (M/D/Y)	
Sex	
Age	
Home Address (Street)	
Address (City, State, Zip)	
Home Phone Number	
Work Phone Number	
E-mail Address	

Date received: _____/_____/_____
 Date of last visit: _____/_____/_____
 Contract cancelled date: _____/_____/_____
 Payment amt. \$ _____
 __V__MC__Cash
 __Check # _____
 Staff Initials: _____

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

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

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:

Risk Factor Stratification (Check all that apply):

Age Impaired Fasting Glucose Family Hx Obesity
 Smoking Sedentary Lifestyle Dyslipidemia Hypertension

Risk for CVD (Circle one): **LOW** **MOD** **HIGH**

Date Cleared: _____ **Staff:** _____

Comments: _____

