

MEMBERSHIP APPLICATION

APPLICANT INFORMATION

Name:

Current address:

City:

State:

Zip Code:

Home Phone:

Alternate Phone:

Date of birth:

E-Mail Address:

Gender: Male Female

MEMBERSHIP TYPE

Type: Undergraduate Student Graduate Student Alumnae/i Faculty Staff Retiree
 Ursuline Residence Park Family DAY PASS

Affiliation: School of Nursing School of Arts and Sciences Graduate School School of New Resources
 Department: Specify _____

FAMILY/INDIVIDUAL MEMBERSHIPS

Name: Relationship: Date of Birth:

Name: Relationship: Date of Birth:

Name: Relationship: Date of Birth:

Name: Relationship: Date of Birth:

EMERGENCY CONTACT

Name:

Address:

Phone:

City:

State:

Zip Code:

Relationship:

USER AGREEMENT

Participant, by Signature below, requests the use of the facility of the College of New Rochelle Wellness Center. It is understood by the participant that:

1. Participant agrees to abide by all Wellness Center guidelines, rules and regulations.
2. Participant's use of the facility is conditioned upon payment in full of fees and charges, continued appropriate affiliation, and maintaining their membership in good standing. Membership is non-refundable and non-transferrable.
3. The College of New Rochelle reserves the right to terminate this membership agreement and participant's use of the Wellness Center.
4. I understand that all individuals using the Wellness Center may be at risk of serious personal injury. The College of New Rochelle is not responsible for injuries suffered by an individual during his/her use of the Wellness Center. Use of the Wellness Center is on a purely voluntary basis. Individuals are encouraged to have a physical examination, adequate health, and insurance prior to using the Wellness Center.
5. The College of New Rochelle shall not assume any responsibility for the loss of personal property or injury to participants.
6. Participants **MUST** present proper ID for facility and program participation.

SIGNATURES

I authorize the verification of the information provided on this form.

Signature of applicant:

Date:

Signature of spouse/family member (if applicable)

Date:

Wellness Center:

Date: