



THE LEAGUE

FOR PEOPLE WITH DISABILITIES, Inc.

Putting Ability First

Wellness Center Membership Application

FOR OFFICE USE ONLY				
Dis.	Pool ND	Regular Ind.	Premier 2 Per.	Family
Initiation Fee: \$ _____				
Pro-Rated Amount: \$ _____				
First Payment: \$ _____				
Total Payment: \$ _____				
Starting Date: _____				
Expires On: _____				
Staff Initials: _____				
Member Barcode #: _____				

Last Name	First Name	Middle Initial	Date of Birth
Street Address			Home Phone
City	State	Zip Code	Cell Phone
Email Address			Work Phone Ext.
In Case of Emergency, Contact	Relationship to Me (parent, child, etc.)	Contact Phone (H/C/W)	

This information helps the League with fundraising resources and grant opportunities to improve and support the needs of the organization.

Disabled:
 Yes
 No
 I choose not to disclose

Has your doctor imposed any restrictions?
 Yes No If yes, please explain below:

Have you been a member before?
 Yes No When? _____

How did you hear about us?
 Doctor Physical Therapist Friend/Family
 Front Sign Other League Program
 Other _____

Are you or your family interested in volunteering?
 Yes No
 Area of interest: _____

The following demographical information is being requested to gather statistical data for reporting to the United Way of Central Maryland. Your information will be held in strictest confidence and will only be used to determine how The League can better serve you and maintain funding by the United Way.

Residency: <input type="checkbox"/> I am a city resident <input type="checkbox"/> I am a county resident _____ County	Race: <input type="checkbox"/> African/American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other: _____
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	

Household Income:
 \$0-\$15,000 \$15,001-\$30,000
 \$30,001-\$50,000 \$50,001-Over

WAIVER:
 I understand that The League for People with Disabilities, Inc. assumes no responsibility for injuries or illnesses which I may sustain as a result of my physical condition or resulting from my participation in an exercise program, the use of any equipment, or other activities. I expressly acknowledge on behalf of myself and my heirs/clients that I assume the risk for any and all injuries or illnesses which may result from these activities. I hereby release and discharge The League, its agents, assigns, or employees from any and all claims for injury, illness, death, loss, or damage which I may suffer as a result of my participation in these activities.

I understand that The League is not responsible for personal property lost or stolen while members and/or program participants are using The League facilities or are on The League property.

Signature of Primary Member

Date

Signature of Parent/Guardian (if member is under 18 or requires an aide)

Date