EVANGELICAL COMMUNITY HOSPITAL

FITNESS CENTER

Membership Application

Name_____ _____ _____
(Last) (First) (MI)

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss. ☐ Dr. ☐ Male ☐ Female

Date of Birth:_____ **E-mail**:_____

Home Address:_____
(Street)

_____ _____ _____
(City) (State) (Zip)

Home Phone #_____ **Work Phone#**_____

Employer_____

Billing Address (If different from above)_____
(Street)

_____ _____ _____
(City) (State) (Zip)

Emergency Contact:_____

Emergency Contact Phone #_____

***Family Memberships*…Please list all members included in the family membership. Thank you!!**

Name	**Date of Birth**

How did you hear about us?

☐ Brochure/flyer ☐ Coach ☐ Employer ☐ Family/Friend ☐ Internet/Website

☐ Newsletter ☐ Doctor: (name)_____

☐ Member ☐ Newspaper ☐ Phone Book/Yellow Pages ☐ Radio

Other, please explain_____