

Personal Information (PLEASE PRINT)

First Name: _____ **Surname:** _____ **Male** **Female**

Marital Status: _____ **Age Category:** 45-64 65-70 71-80 81-90 90+

Address: _____ **Apt #:** _____

City: _____ **Postal Code:** _____

Home Phone: _____ **Alternate Phone:** _____

Email address: _____

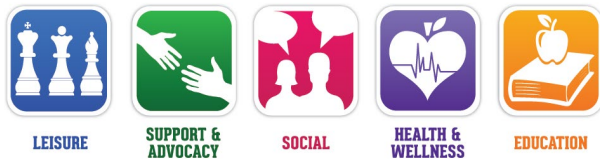
Emergency Contact (PLEASE PRINT)

Relation to You:

Full Name: _____

Home Phone: _____ **Alternate Phone:** _____

What are your goals in becoming a member?



- YES! I would like to take part in your FREE FITNESS and FALLS Prevention classes at the Centre.**
- YES! I agree to have my contact information provided to the Central Local Health Integration Network (CLHIN) to complete the mandatory telephone health assessment if I have not already done so.**

Better Living Health and Community Services respects your privacy. We protect your personal information and adhere to all legislative requirements with respect to protecting privacy. We do not rent, sell or trade our mailing lists. The information you provide us will only be used to for planning purposes through aggregate statistical reporting for our various funders and to assist us in analyzing the usage and population trends within our community. We will also use this information to keep you informed and up-to-date on the activities of Better Living Health and Community Services. If you have any questions about our privacy practices or you would like to be excluded from future mailings, please contact our Privacy Officer at (416) 447-7244 ext. 736.

Photos, digital photos or videos, may be taken at any time for Better Living Health and Community Services. These images may be used for promotional materials including program guides, brochures, displays, marketing materials, fundraising and for our website. I acknowledge that images in which I appear may otherwise be displayed to the public or used for other formal or training purposes.

I hereby release Better Living Health and Community Services and any third party contract instructors from any damages resulting from any accident or injury that is caused by or arises from my participation in any programs offered. I assume full responsibility for my participation and understand that all programs (especially those involving physical activity) have associated risks. I further acknowledge that I am physically fit to participate in the activities I select.

Signature: _____ **Date:** _____

Valid Year	19/20	20/21	21/22	22/23	23/24
Member's Initial					

FOR OFFICE USE ONLY

Picture Number:

Key Tag #:

Membership # Issued:

Date joined:

1. Valid Year:	Amt. Paid:	Method:	Processed By:
2. Valid Year:	Amt. Paid:	Method:	Processed By:
3. Valid Year:	Amt. Paid:	Method:	Processed By:
4. Valid Year:	Amt. Paid:	Method:	Processed By:
5. Valid Year:	Amt. Paid:	Method:	Processed By:
6. Valid Year:	Amt. Paid:	Method:	Processed By:

YES! I have forwarded this clients information to the Fitness and Falls Prevention Coordinator for additional follow up and assessment.

Notes:
