WELLNESS PROGRAM RULES AND REGULATIONS

* All Fitness Memberships include an orientation session to familiarize you with the fitness equipment and its proper use. This session must be completed before you begin any unsupervised use of fitness equipment.

* Allowing others in the facility is prohibited. No guests are permitted. Your membership must not be used by or assigned to another person

* Members must follow directions from staff with respect to use of the equipment and instructions or limitations concerning exercise.

* All equipment should be cleaned by the member after each use and returned to its original setting and position.

* Ages 12 through 14 must be accompanied by a parent legal guardian or coach, NO EXCEPTIONS.

* Any Wellness Center equipment or other property, damaged or destroyed due to the negligence or willful misuse of the member, will be repaired or replaced at the member's expense, and may result in loss of membership privileges at our discretion.

* Use of the phone for any calls other than emergency or Wellness Exercising use is prohibited.

* Personal training can only be done by Hand County Memorial Hospital staff only.

* All exercises, including the use of weights and use of any and all machinery and equipment designed for exercising, shall be at the member's sole risk. The Wellness program.is not responsible for any accident that may occur with exercise and weight equipment or on the premises during any staffed or unstaffed hours. Please refer to the Waiver and Release for details.

* Each Member must use his or her 24-hour access code when using the Forever Fit Wellness Program during staffed and unstaffed hours.

APPLICANT'S STATEMENTS

I acknowledge that I have been advised to receive a physical examination and consult with a physician before joining the Wellness Program and beginning a program of physical exercise. I certify that I am in good health and have no conditions or limitations that would prevent me from utilizing the membership in a safe manner.

I do hereby agree to comply with each and all of the policies, terms and rules of the Forever Fit Wellness Program, which are set forth above or are posted at the facility, both now in effect or as amended at any time during the term of this membership and any future memberships. I recognize that my signature below creates a contractual obligation.

CANCELLATION AND REFUND POLICY

This agreement may be cancelled if I become permanently disabled and provide written evidence signed by a physician of this disability to the Wellness Center at the address above. Should I permanently move my residence more than 30 miles from the Wellness Center facility this agreement may be cancelled on thirty (30) days notice except that I will still be responsible for payments due up to the date of cancellation. Member will be responsible for any legal or collection fees in the event of non-payment at a minimum of $20.00.

I MAY CANCEL THIS AGREEMENT BY MIDNIGHT OF THE THIRD BUSINESS DAY AFTER THE DATE OF THIS AGREEMENT, AND SUCH CANCELLATION MUST BE IN WRITING. IN THE EVENT THE WELLNESS CENTER CLOSES AND CEASES DOING BUSINESS, I WILL NO LONGER BE OBLIGATED TO MAKE PAYMENTS UNDER THIS AGREEMENT. I HAVE READ AND AGREE TO THE ABOVE TERMS.

RELEASE AND WAIVER OF LIABILITY

I,_____ understand that there are risks associated with exercise and other forms of physical activity in which I will engage while at the Wellness Center. These risks include, but are not limited to abnormal blood pressure, fainting, heart disorders and heart attack, dehydration, heat exhaustion, sprains, back pain, and metatarsalgia (bruising of joints). Exercise beyond one's physical limits and/or accidents involving exercise equipment may result in serious injury or death.

Accordingly, I also understand that I should consult with a physician of my choosing before engaging in any exercise or fitness program or using the equipment and facilities available at the Wellness Center. I certify that I do not have any limiting physical condition or disability that would preclude an exercise program or use of the equipment and facilities available at the Wellness Center.

I also acknowledge that the Wellness Center premise is staffed on only a part time basis and, if I elect to use the facility at other times, I do so at my own risk. I have been encouraged to exercise with a friend during non-staffed hours of operation and understand that while access to the facility is intended to be restricted to those with' an access code and videotape cameras have been installed, the facility is not monitored on a 24 hour basis so I should take reasonable steps to protect my own security.

In consideration of the permission granted to the undersigned to participate in the Wellness Center, I hereby assume all risks associated with the exercise programs, use of the exercise equipment and activities offered by or through the Wellness Center. I hereby waive, release and discharge, and agree to indemnify and hold harmless, from all liability and as to any and all claims, loss, damage or cost, the Wellness Center and its owner, employees and agents for personal injury(ies), death, and /or property damage and actions of any kind which may. hereafter occur to me or to any other person while at the Wellness Center or premises, whether caused by negligence, recklessness or otherwise.

I HAVE READ THE RELEASE AND WAIVER OF LIABILITY, UNDERSTAND AND AGREE TO ITS TERMS AND HEREBY VOLUNTARY RELEASE ALL CLAIMS TO THE FULLEST EXTENT PERMITTED BY LAW.

Date:_____ Name:_____

Signature:_____

Parent or Guardian (if applicable): Name:_____ Signature:_____

Date:_____

Hand County

Memorial Hospital Inc.

300 West 5th Street
Miller, SD 57362
605-853-0364
Fax 605-853-0333

MEMBERSHIP AGREEMENT

By signing below you agree to purchase a membership in the Wellness Program on the terms and conditions described in this Agreement, including the terms of the Cancellation and Refund policy on page 3. You agree to make the payments shown in the Agreement and to abide by the Rules and Regulations of the Wellness Program, and as they may be from time to time amended, in our sole discretion. As part of this Agreement, you understand that reference.

Last Name First Middle Initial Phone Number

Current Mailing Address City State Zip Code Date of Birth

In case of emergency, call: Relationship Phone Number

Additional Member Information for Family Memberships

Last Name First Middle Initial Phone Number

Date Of Birth In case of emergency, call: Relationship Phone Number

I have also read and agree to the terms of this agreement.

Signature Date