



MEMBERSHIP FORM

MEMBER LAST NAME

[Redacted]

Last Name

First Name

Middle Initial

[Redacted]

[Redacted]

Home Phone

Cell Phone

Birthdate (MM/DD/YYYY)

[Redacted]

Male Female Non-Binary

Email

[Redacted]

Street Address

[Redacted]

Are you a Veteran? Yes No

City

State

Zip

[Redacted]

Emergency Contact: First and Last Name

Relationship

Phone Number

[Redacted]

Doctor's Name

Phone Number

MEMBER FIRST NAME

MEMBERSHIP Please select: Regular (12 months) All Access (Continuous)

Regular Membership requires an annual non-refundable fee and runs from 12 consecutive months from date of registration.

All Access Membership requires Recurring Payment Authorization Form or annual non-refundable fee, and is a continuous membership.

Membership Change Form required to upgrade, cancel or request leave of absence for All Access Membership.

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MEMBERSHIP FINANCIAL ASSISTANCE Available for both Memberships.

VOA raises funds to ensure that everyone has access to membership.

Interested in financial assistance? The process will be discreet and confidential. Yes

GIVE THE GIFT OF GIPSON Donate to provide membership(s) to low-income members (50+)

Would you like to contribute to the Carl Gipson Center in order to provide financial assistance so that others can become members?

Donate Regular Membership: Yes Donate All Access Membership: Yes

Donate Other Amount: (Please list): _____

INITIALS



All medical information will be kept confidential by the Carl Gipson Center staff and emergency medical personnel.

MEDICAL HISTORY

Please list any Medical Conditions for which you have received, or are receiving treatment for.

- | | | |
|--|--|--|
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Asthma/Lung Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Bypass Operation |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Other (Please specify): _____ |

DAILY MEDICATION(S) & DOSAGE

ALLERGIES

Agreement & Release Of Liability

The Carl Gipson Center offers a variety of physical activities, which may include but are not limited to group exercise classes, Wii® games, table tennis, the self-serve Mt. Pilchuck Fitness room, and others. By signing below a participant attests that they are capable of determining their ability to participate in the activity. The Carl Gipson Center has not and will not render any medical advice regarding their physical condition. Participants are aware that participation may result in accident or injury, and assume all risk related to their participation in the activity. Participants release and hold harmless Volunteers of America Western Washington (VOAWW), the City of Everett, and all officers, employees, assigns, and agents from all claims (including personal injury claims) arising from or relating to their participation in the activities at the Carl Gipson Center.

Participants give their permission for the staff to call the number(s) they have provided regarding information and updates about the Carl Gipson Center, and give their permission for VOAWW to use any photograph and video taken of them at the Carl Gipson Center for advertising and publication purposes.

By signing below, I agree and affirm the foregoing Release of Liability. I understand that the membership fee is non-refundable, and I agree to abide by the Carl Gipson Center Code of Conduct.

Printed Name	Date	Signature

STAFF TO COMPLETE

Date Processed: _____

Initial:

Payment Processed (List amount):

Member Handbook provided

Regular Membership: _____

Parking Pass offered

All Access Membership: _____

Key Fob provided

Donation: _____

Membership Rates & Policies Provided

Recurring Payment Authorization Form (All Access)

TOTAL: _____

Financial Assistance Information Provided (if applicable)