

MEMBERSHIP APPLICATION FORM

**Please complete ALL SECTIONS of the form below using BLOCK CAPITALS.
If you require assistance please ask at the centre reception.**

Last / Family Name:		First Name:		Title <i>(select as appropriate):</i>	
Date of Birth:		Middle/Other Name(s):		Gender:	Office Use Membership No:
Home (Permanent) Address:			Work (or Term-time) Address:		
Postcode:			Postcode:		
Telephone:			Telephone:		
Mobile Phone:			e-mail Address:		
Job Title :		Company/University :		Department :	
University ID No. (if applicable):		ID Barcode No. (if applicable):		ID Card Expiry Date (if applicable) :	

1.	Have you ever suffered from any heart condition?	
2.	Have you been diagnosed with high blood pressure?	
3.	Are you pregnant?	
4.	Are you over 69 years of age?	
5.	Do you have any other conditions/illnesses/injuries that you feel we should be made aware of?	
<p>IF YOUR ANSWER IS 'YES' TO ANY OF THE ABOVE, YOU ARE ADVISED TO CONSULT YOUR DOCTOR TO APPROVE YOUR INVOLVEMENT IN PHYSICAL ACTIVITY.</p> <p>Additional Information:</p> <p>Please tick box if you have a condition that may require you needing additional assistance in the event of an evacuation</p> <p>PLEASE NOTE: This medical information you have declared above is valid for a period of 12 months from the completion date. The information given becomes invalid if your condition changes. Should you need to answer YES to any of the above 5 questions, you are advised to consult your doctor and to inform the Centre Manager / Supervisor before your next visit.</p>		

- I have read, understand and accept the Terms & Conditions of membership available.
- Terms & Conditions are available to download at www.cf.ac.uk/sport or at Centre Receptions.
- I understand that my details will be entered onto a computerised membership system and that information will be retained in compliance with the Data Protection Act 1998.
- Your details may be used for internal marketing. Please tick box if you wish to opt out

Signed: _____ **Date:** _____