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** (*select as appropriate*): -	
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?	-

IF YOUR ANSWER IS 'YES' TO ANY OF THE ABOVE, YOU ARE ADVISED TO CONSULT YOUR DOCTOR TO APPROVE YOUR INVOLVEMENT IN PHYSICAL ACTIVITY.
Additional Information:

Please tick box if you have a condition that may require you needing additional assistance in the event of an evacuation ☐

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.

- **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:** _____