



ID _____

Paid _____

Date _____

REGISTRATION – FALL 2017

Name _____

Department _____

Email _____

Phone _____

Program Rules:

1. Each participant will pay a **non-refundable** fee* of \$40 or \$20(members) to enroll in the program.
* Cash or check made payable to "University of Rochester". **Credit cards are not accepted.
2. Registration period ends on Wednesday September 27 at 4pm.
3. Program dates are October 2 – November 17, 2017.
3. Participants will earn "pounds" in weight loss for each session attended.
4. Participants will be weighed confidentially once per week. Any participant missing more than 2 weekly weigh-ins, at sessions, will be disqualified from winning a prize and will be unable to use the Fitness Center for the duration of the program.
5. Prizes will be awarded to (at least) the 5 participants with the biggest percentage of body weight lost.
6. Participants that are not members will be able to use the Fitness Center during the program, once they have completed an orientation.

I understand that there are some risks involved with any weight loss program. My signature confirms that I acknowledge these risks and that I am choosing to enroll in this program voluntarily. It also confirms that I have read the rules and information on the program and that I agree to the rules of the program listed above.

Signature _____ Date _____

University of Rochester Medical Center
Fitness Center
Non-Member Program Participation Agreement

In consideration of participating in a program sponsored by the University of Rochester Medical Center Fitness & Wellness Center ("Center"), I hereby:

1. Agree to make myself familiar and comply with all the rules and regulations of the Center, its personnel and the program I am participating in, and to make myself aware of any changes as they occur. I understand that the Center has the right to terminate my participation if I fail to comply or if I fail to follow the instructions of Center personnel.
2. Understand that I will be engaging in a program and/or activities that involve the risk of serious injury, including permanent disability and death, which might result not only from my own action or inaction, but also from the action or inaction of others, the rules of play, or the condition of premises or equipment. I acknowledge that there may be other risks not known to me or foreseeable.
3. Grant permission, in the event of an injury, to have a doctor, nurse, athletic staff, or medical emergency personnel provide me with emergency medical treatment and agree that I will bear any costs associated with such treatment.
4. Release, waive, discharge, and covenant not to sue the University of Rochester, its employees, instructors, trainers, or agents for any and all claims, demands, losses, or damages on account of injury, including permanent disability and death, or damage to property caused or alleged to be caused in whole or in part by the negligence of the releasers or otherwise.

I HAVE READ THE ABOVE AGREEMENT, INCLUDING THE WAIVER AND RELEASE, AND UNDERSTAND THAT I GIVE UP SUBSTANTIAL RIGHTS BY SIGNING BELOW AND AFFIRM THAT I **DO SO** VOLUNTARILY.

Print name

Signature

Date

Your E-mail Address

Your Daytime Phone

Emergency Contact Name

Emergency Contact Phone