



**Member Information:**

\_\_\_\_\_  
First Name Last Name

\_\_\_\_\_  
Member Mailing Address City State Zip Code

\_\_\_\_\_  
Member Home Phone Number Work Phone Number Cell Phone Number

\_\_\_\_\_  
Emergency Contact Phone Number Relationship

\_\_\_\_\_  
Member Email Address Birth Date

**Payment Information:**

\_\_\_\_\_  
Credit Card Type Credit Card Number

\_\_\_\_\_  
Expiration Date Security Code Credit Card Billing Zip Code

**OR**

\_\_\_\_\_  
UF Health ID Number Department

**Initials:**

\_\_\_\_\_  
\$50 Initiation Fee\*

\_\_\_\_\_  
\$100 Cancellation Fee\*

\_\_\_\_\_  
Referred By

**STAFF MEMBER USE ONLY:**

**Y/N** \_\_\_\_\_

Free trial Free Trial Start Date Free Trial End Date

\_\_\_\_\_  
Membership Start Date  Employee Incentive

<input type="checkbox"/> \$9.99 General Fitness*	<input type="checkbox"/> \$75/month 12 Appts Medical Fitness
<input type="checkbox"/> \$19.99 General Fitness*	<input type="checkbox"/> \$85/month Unlimited Medical Fitness
<input type="checkbox"/> \$24.99 General Fitness*	<input type="checkbox"/> \$237 (3 month) Medical Fitness
<input type="checkbox"/> 10 pack General Fitness	<input type="checkbox"/> 10 pack Medical Fitness
	<input type="checkbox"/> Personal Training
	<input type="checkbox"/> Other: _____

\_\_\_\_\_  
Shape Code

\_\_\_\_\_  
Member Signature

\_\_\_\_\_  
SFWC Staff Member Signature

\_\_\_\_\_  
Sign-Up Date

\_\_\_\_\_  
State ID #