



Individual Exercise Program  
Release of Liability

I, \_\_\_\_\_, the undersigned agree and understand that:  
(Please print full name)

1. Weight training, aerobic exercise, and other cardiovascular exercise may be hazardous and result in injury to myself or other members; and
2. Other aspects of weight training, aerobic exercise and cardiovascular exercise may result in injury to me or other members.

I assume all risks of injury incurred or suffered while on the premises of Providence Hospital – Center for Rehabilitation and Fitness. Moreover, I release and agree not to sue if agents, servants, associations, employees, or anyone connected with Providence Hospital.

Providence Center for Rehabilitation and Fitness has agreed to allow the undersigned to utilize the facility's exercise equipment during operational hours, Monday through Friday, unless otherwise indicated, to continue his/her fitness program.

I understand that I am no longer under the direct care of a Physical Therapist and have been formally discharged from Physical Therapy. The F.I.T. Program is designed to be a medically supervised INDEPENDENT service.

I understand the fees are as follows:

1 month membership (exercise only)	\$ 40.00
3 month membership (exercise only)	\$105.00
Exercise Progression Visit	\$30.00

I, the undersigned member, acknowledge that I have read and understand the above contract and enter into it voluntarily.

Additional terms: Providence Center for Rehabilitation and Fitness shall not be responsible for the loss of member's personal property, either by reason of theft or loss from the premises.

This contract cannot be canceled or rescinded, nor shall the membership fee be refunded, except on terms and within the sole discretion of Providence Hospital, nor shall any membership be transferable to another person, or persons.

\_\_\_\_\_  
Participant's Signature

\_\_\_\_\_  
Date

Phone Number that you can be reached during the day: \_\_\_\_\_