Electric Boat Fitness Center Application

Membership Benefits:

-Access to all three fitness centers,
New London, Groton, & Kings Highway, 24/7.
-FREE personal training.
-FREE & unlimited fitness classes.
-Access to lockers & showers.
-Commercial grade cardio equipment.
-Joining a community.

Membership Fees:

Initial Enrollement Fee: $30
*This fee is non-refundable

Payroll Deduction
Hourly - $3.00 per pay period
Salary - $6.00 per pay period

SupShip & Non-EB Employees
$39 per quarter
Checks only - made payable to EB Corp

MINIMUM SIX MONTH SIGN-UP REQUIRED

Application Directions:

1) Fill out application in its entirety, do not leave anything blank.

2) Sign the application.

3) Submit your completed application in the application drop box located outside each Fitness Center location. OR e-mail your completed application to EBFitness@gdeb.com

Once your applicaiton is recieved your application will be submitted to EB Medical for approval. When your applicaiton is approved a fitness center staff member will contact you to sign your payroll deduction forms and Liability Waiver.

The $30 initial enrollment fee is non-refundable and will be collected by payroll deduction. SupShip and Non-EB employees will pay intial enrollment fee and quarterly dues by check.

For any questions, please contact:

EB Fitness Center
Groton/Kings Highway: 860-433-1515
New London: 860-867-1266
EBFitness@gdeb.com

Do not leave ANY of this application blank.

Application cannot be processed with missing information.

DEMOGRAPHIC INFORMATION:

Today's Date: _____

Name: (last)_____(first)_____(mi)_____

Address: _____ City_____ State____ Zip _____

Telephone: _____Badge Number: _____ Department Number: _____

Email: _____

Date of Birth: _____ Age: _____ Gender: Male☐ Female☐

Are you a rejoin? _____ Which location were you a member at? _____

Employment: Salary☐ Hourly☐ SupShip☐ Intern☐ OTHER (specify)☐

*Physician: _____

Name/Location of Practice: _____

Phone: _____ Date of last check-up: _____

**Must Provide a Primary Care Physician outside of EB Medical Dept. (Yard Hospital)*

Height: _____ ft. _____in. Weight____ lbs.

Most Recent Blood Pressure Measurement: _____/_____ (Date: _____/_____/_____)

* Don't know your blood pressure? Stop by the Yard Hospital or Fitness Center for a measurement. *

In case of **EMERGENCY**, contact:

Name: _____ Relationship: _____ Phone: _____

WHICH FITNESS CENTER SERVICES ARE YOU INTERESTED IN?

(No additional charge) (Check all that apply)

- ☐ Group Classes
- ☐ 1 on 1 Personal Training
- ☐ Movement/Posture Assessment
- ☐ Gym Equipment Tutorial
- ☐ Stretching/Mobility Lesson
- ☐ Foam Rolling Lesson
- ☐ Remote Training/Written Plans
- ☐ Not Interested at This Time

MEDICAL HISTORY QUESTIONNAIRE

Directions:

- At the start of each section, place a check on the line if you have no **CURRENT or PAST** (within five years) history of health conditions relating to that area.
- If "No Current or Past Conditions" box is checked, move on to the next section of the questionnaire.
- If unchecked, see the conditions below and circle if each is a current or past issue, and explain below.

1. Cardiac (Heart) disease/condition

No Current or Past Conditions ☐

Heart attack
Heart surgery/Bypass
Artery disease
Irregular heartbeat/murmur
Congenital heart disease
Rheumatic heart disease
Chest pain/tightness
Swelling in ankles
High blood pressure
High cholesterol
Other

Explain any/all cardiac conditions:

2. Pulmonary (Lung) disease/condition

No Current or Past Conditions ☐

Asthma
Shortness of breath
Labored breathing
COPD
Smoker
Other

Explain any/all pulmonary conditions:

3. Musculoskeletal (Bone/Muscle) disease/condition

No Current or Past Conditions ☐

Arthritis
Injury to low/mid/upper back
Pulled/strained muscle/joint
Joint aggravated by activity
Hernia
Other

Explain any/all musculoskeletal conditions:

4. Other disease/condition **No Current or Past Conditions** ☐

Stroke
Epilepsy
Diabetes
Lightheadedness/Fainting
Hypoglycemia/Anemia
Other

Explain any/all other conditions:

5. Past (within 5 years) hospitalization and dates: _____

Reason: _____

Past (within 5 years) surgeries and dates: _____

Reason: _____

6. Do you take any medications on a regular basis? **Yes** ☐ **No** ☐

If yes, please list medications and reasons for taking:

_____ _____

_____ _____

7. Do you have any other medical conditions or physical limitations which should be considered prior to your participation in an exercise program? If yes, please explain.

I HEREBY CERTIFY that all statements and answers provided by me in this form are complete and true to the best of my knowledge. I understand and agree that my participation in the company health and fitness program is conditional upon full disclosure of all medical information, and that failure to do so shall constitute grounds for immediate termination from the program.

I also understand that if my physical condition changes or if my physician notes any change, I must see the fitness center staff to see if my exercise regimen should be modified.

_____ _____
Signature of Applicant Date

*** The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring Genetic Information of an individual or family member of the individual, except as a specifically allowed by this law. To comply with this law, we are asking that you do not provide any GI when responding to this request for medical information. "Genetic Information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family medical history, the results of an individual or an individual's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and Genetic Information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

****

FOR E.B. MEDICAL/CFC STAFF USE ONLY

☐ *Employee is medically cleared to use the Fitness Center*

☐ *Employee is not cleared and requires physician's clearance prior to using fitness center*

SIGNIFICANT MEDICAL CONDITIONS:

_____

EB Medical Staff Signature