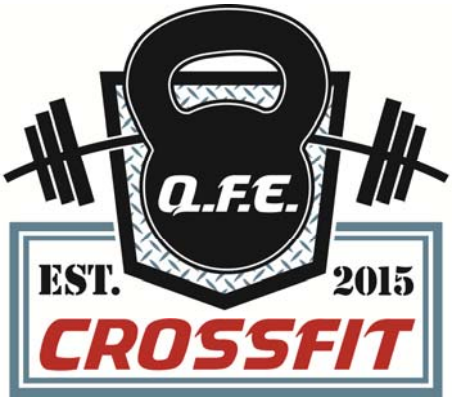

SOUTHEASTERN HEALTH EMPLOYEE MEMBERSHIP APPLICATION

APPLICANT #1

NAME: _____ _____ _____

FIRST MIDDLE LAST FEMALE MALE

(THE FIRST NAMED APPLICANT WILL BE LISTED AS THE BILL PAYER)

ADDRESS: _____

CITY ZIP-CODE

SSN#: _____

HOME PHONE: _(_____)_____ **BIRTHDATE**: _____

DEPARTMENT: _____ **WORK PHONE**: (____)_____ **EXT**._____

E-MAIL ADDRESS: _____

*******IMMEDIATE FAMILY MEMBERS ONLY*******

(C0MPLETE THIS SECTION)

APPLICANT #2

NAME: _____

FIRST MI LAST

SSN#: _____

HOME PHONE: _(____)_____ **BIRTHDATE**: _____

EMPLOYER: _____ **WORK PHONE**: _(____)_____

RELATIONSHIP TO APPLICANT: _____ **E-MAIL ADDRESS**: _____

EMERGENCY CONTACTS:

NAME: _____ PHONE: _(___)_____

NAME: _____ PHONE: _(___)_____

Dues Per Month	Application Fee (If waived, reason)	Single or Couple	If Corporate, Name of Company
	NONE		**Southeastern Health**

*****FEES ARE SUBJECT TO CHANGE*****

______ **Bank Draft (Checking, Savings)** ______ **Debit/Credit Card Draft (Visa, MasterCard)**

______ **SRMC Payroll Deduct (PRN NOT allowed to payroll deduct)** **Employee #** ____________________

Bank Draft Authorization

I authorize CrossFit Q.F.E. to draft from my account, as specified above, the monthly account balance which I understand may include any return fees, overdue payments, e.t.c. on the 10th day of each month. It is my responsibility to make sure I notify CrossFit Q.F.E. of any changes to my routing number, account number, card number, or expiration date.

Name of Bank ________________________________ Checking _____ Savings _____

Bank's ABA # ________________________________ Bank Account # _______________________________

Credit/Debit Card Authorization

Visa ___________ Mastercard___________ Debit (ATM) Card Yes___ No___

Account Number: ______________________________ Expiration Date: ______

Name of Issuing Bank___________________________

*****$35.00 FEE ON ALL RETURNED OR UNPROCESSED ITEMS REGARDLESS OF RETURN/UNPROCESSED REASON*****

****

Terms of Agreement

This agreement may be cancelled in writing within (3) three working days after the date of the contract, with a full refund**.**
A (30) thirty-day written notice is required for all other cancellations ___________________ **(INITIALS REQUIRED)**

Memberships are non-transferable. I hereby authorize CrossFit Q.F.E. to deduct from my paycheck, bank account or credit/debit card the monthly balance of my account, to include any overdraft fees, service charges, overdue payments, etc. I understand that I may not make any changes to my draft information after the 1st of a given month.

I am aware that if I cancel between the 1st and the 15th of a billable month, I will be required to pay the current month's dues as well as any past dues. I am aware that if I cancel from the 16th through the last day of the billable month I will be required to pay the current month's balance and the dues for the month to follow and that my membership is active until the end of that following month. ALL CANCELLATIONS MUST BE IN WRITING. Even if my employment with Southeastern Health terminates, I understand that a WRITTEN cancellation notice must be given.

My signature below confirms my consent for any person associated with my membership to be photographed for membership security reasons. My signature does also hereby release CrossFit Q.F.E., Southeastern Health, its affiliates, agents and representatives from any liability, legal responsibility and/or claims of damages, demands and actions that may arise as a result of my voluntary participation.

By signing this application, I hereby agree to the terms of this agreement and will abide by the rules, regulations and guidelines of CrossFit Q.F.E.

_____________________________________ _______________
Signature of Member Date

_____________________________________ _______________
Signature of CrossFit Q.F.E. Representative Date

REVISED FORM DATE 03/10/15