

Wapsi Physical Therapy & Fitness Center

Membership Registration Form

Name _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Age: _____ Gender: _____ Marital Status: _____ Occupation: _____

Date of Birth: ____/____/____

Phone: Home: _____ Work: _____

Cell: _____ E-Mail: _____

Employer: _____

Emergency Contact -
Name _____ Phone: _____

How did you hear of us? _____

Physician Name: _____

Physician Address: _____

Physician Phone: _____ Office location _____

Family Memberships

Name _____ DOB _____ Phone _____

Name _____ DOB _____ Phone _____

Name _____ DOB _____ Phone _____

Name _____ DOB _____ Phone _____

Name _____ DOB _____ Phone _____

If we do not see you for a few weeks would you like a friendly motivational phone call ___ Email ___

_____ I have read and agree to comply with the Fitness Center Policies. I understand that misconduct will not be tolerated and may result in membership being suspended or revoked.

For Office use only

Membership _____

Membership Number _____

Paid by _____ Amt. _____

Entered in computer by _____