

## CROSSFIT NEW HAVEN MEMBERSHIP AGREEMENT

Between CrossFit New Haven and (please print name) \_\_\_\_\_

**Services Provided:** CrossFit New Haven obligations hereunder and the undersigned Member's membership are conditioned upon (i) Member executing this Agreement and initializing as designated, (ii) Member executing a Release in the form provided by CrossFit New Haven, and (iii) Member otherwise complying with this Agreement (including, without limitation, the Rules defined below) For purposes of the foregoing conditions, the term "member" shall include each individual (i.e., spouse and children) included in a membership. Conditioned on the foregoing, operating hours, as established from time to time, and (b) participate in any one or more group classes offered by CrossFit New Haven from time to time.

**This is not an "open gym" format. By class or appointment-only training, unless otherwise noted.**

The facility is located at the address of 1175 State Street New Haven, CT. Hours of operation as follows:

1. Operating Hours; varies; see [www.crossfitnewhaven.com](http://www.crossfitnewhaven.com)
2. Weekly Classes; varies; see [www.crossfitnewhaven.com](http://www.crossfitnewhaven.com)

CrossFit New Haven may alter its location, operating hours, type and quantity of equipment, and type and frequency of its classes from time to time in its sole discretion. Fitness training is an evolving science. Thus, CrossFit New Haven reserves the right to change its routines, classes and equipment to accommodate such evolution.

### **Membership: Payment**

Member hereby subscribes for the following type of membership (Check all that apply):

\_\_\_\_\_ Individual \_\_\_\_\_ Spouse (20% discount)  
\_\_\_\_\_ Children 14-18 (20% discount) \_\_\_\_\_ Student (20% discount)  
\_\_\_\_\_ Military (active)/Fire/Police (20% discount)

### **Length of Membership:** *All Fees will be subject to 6% CT State Sales Tax.*

\_\_\_\_\_ 3 /wk Month-to-Month (\$125/mth) \_\_\_\_\_ 3/wk Auto Pay (\$100/mth)  
\_\_\_\_\_ Unlimited Month-to-Month (\$175/mth) \_\_\_\_\_ Unlimited Auto Pay (\$150/mth)  
\_\_\_\_\_ 5 PT Sessions (\$275) \_\_\_\_\_ On-Ramp/ 12 sessions (\$150)

Credit card/Debit Card #: \_\_\_\_\_ Exp Date: \_\_\_\_\_

ACH: Routing No: \_\_\_\_\_ ACH Account No: \_\_\_\_\_

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

## CROSSFIT NEW HAVEN

### Manner of Payment:

**Compliance with Rules:** Member shall abide by all membership and facility rules and regulations established by CrossFit New Haven, which may be posted at the facility, provided in writing, or issued orally and which may be amended from time to time in the sole discretion of CrossFit New Haven (collectively, "Rules"). I agree that improper or unauthorized use of the facility or violation of the Rules may result in member suspension or cancellation at CrossFit New Haven's discretion.

**General:** This Agreement, the Release and the Rules represent the complete understanding between Member and CrossFit New Haven. No representations, written or oral, other than those contained in this contract are authorized or binding upon CrossFit New Haven. Member understands that he/she is obligated to pay the membership fee regardless of whether Member uses the facility. Member agrees to promptly notify CrossFit New Haven in writing of any changes of address, phone, and/or bank account/credit card information. At the end of the term of this membership contract, it shall continue in effect on a month to month basis unless new rates have been installed or you provide notice of cancellation to terminate this contract.

**Cancellation Rights:** You may cancel this contract for one or more of the following reasons by delivering written notice of cancellation to: CrossFit New Haven, Attn: Manager, 1175 State Street Unit 201, New Haven, CT 06511

1. **Relocation:** If member moves his/her residence more than twenty-five (25) miles from the Facility, Member may cancel his/her membership subject to a \$50 service charge.
2. **Death; Disability:** In the event that a Member dies or becomes disabled, then upon notice to CrossFit New Haven the Agreement shall terminate as of the date Member could no longer use the membership. If prepaid, the Member shall be entitled to a pro rata reimbursement for the period after termination. For purposes of this provision, "disability" means a condition which precludes the member from physically using the facilities as verified by a physician.

YOU, THE BUYER, MAY CANCEL THIS AGREEMENT AT ANY TIME PRIOR TO MIDNIGHT OF THE FIFTH (5<sup>TH</sup>) BUSINESS DAY OF THE HEALTH STUDIO AFTER THE DATE OF THIS AGREEMENT, EXCLUDING SUNDAYS AND HOLIDAYS. TO CANCEL THIS AGREEMENT, MAIL OR DELIVER A SIGNED AND DATED NOTICE, OR SEND A TELEGRAM WHICH STATES THAT YOU, THE BUYER, ARE CANCELING THIS AGREEMENT, OR WORDS OF SIMILAR EFFECT. SUCH NOTICE SHALL BE SENT TO: CROSSFIT NEW HAVEN, ATTN: MANAGER, 1175 STATE STREET UNIT 201 NEW HAVEN, CT 06511. IF THE TOTAL FEES DUE HEREUNDER EXCEED \$1500, THEN TERMINATION RIGHT SHALL BE EXTENDED TO 45 DAYS AFTER IT HAS BEEN EXECUTED BY THE MEMBER.

THE TOTAL TERM OF THIS MEMBERSHIP AGREEMENT IS \$ \_\_\_\_\_

I certify that I have read and understand all of the terms of this agreement and agree to abide by all of the terms of this Agreement.

Member (please sign): \_\_\_\_\_

**CrossFit New Haven**

**RELEASE FROM LIABILITY AND ASSUMPTION OF RISK (ADULT)**

***PLEASE READ CAREFULLY, COMPLETE, AND INITIAL EACH PARAGRAPH BEFORE SIGNING***

I, \_\_\_\_\_, have applied to CrossFit New Haven's CrossFit based exercise training program (the "Program") at CrossFit New Haven's facility located at 1175 State Street, Unit 201, New Haven, CT 06511.

\_\_\_\_\_ I hereby acknowledge that I should consult with my physician before beginning any exercise program.

\_\_\_\_\_ I certify that I am not aware of any medical condition which would render me unfit to participate in any exercise program and that I will inform CrossFit New Haven immediately of any change in my medical condition.

\_\_\_\_\_ I agree that if I experience symptoms such as shortness of breath, chest pain, unusual fatigue, dizziness or fainting, or extreme pain, whether or not I am under the direct supervision of my trainer, I will immediately stop exercising and inform a representative of CrossFit New Haven of my symptoms.

\_\_\_\_\_ I authorize any representative of CrossFit New Haven to obtain emergency medical treatment for me, including transportation to a hospital or other medical facility.

\_\_\_\_\_ I UNDERSTAND AND ACKNOWLEDGE THAT THERE ARE RISKS INHERENT IN ANY EXERCISE PROGRAM INCLUDING BUT NOT LIMITED TO HEART ATTACK, STROKE, ORTHOPEDIC INJURY, INJURIES CAUSED BY THE USE OF EXERCISE EQUIPMENT AND OTHERS. THESE INJURIES CAN OCCUR SUDDENLY AND WITHOUT WARNING, AND MAY RESULT IN DEATH. I AM VOLUNTARILY PARTICIPATING IN THIS TRAINING PROGRAM WITH KNOWLEDGE OF THE DANGERS INVOLVED, AND I HEREBY AGREE TO ACCEPT ANY AND ALL RISKS OF INJURY OR DEATH, AND VERIFY THIS STATEMENT BY PLACING MY INITIALS ABOVE.

\_\_\_\_\_ FOR AND IN CONSIDERATION OF PERMITTING ME TO PARTICIPATE IN THE PROGRAM, I, FOR MYSELF AND FOR MY HEIRS, BENEFICIARIES, AND PERSONAL REPRESENTATIVES, HEREBY RELEASE AND FOREVER DISCHARGE CROSSFIT NEW HAVEN AND ITS DIRECTORS, OFFICERS, MEMBERS, MANAGERS, EMPLOYEES, AGENTS, ATTORNEYS, INSURERS, SUCCESSORS, AND ASSIGNS (COLLECTIVELY, "CROSSFIT NEW HAVEN PARTIES"), FOR ANY AND ALL CLAIMS, DEMANDS, DAMAGES, LOSSES, LIABILITIES, RIGHTS, ACTIONS, CAUSES OF ACTION, EXPENSES, AND SUITS OF ANY KIND WHATSOEVER, FORESEEN OR UNFORESEEN, FOR PERSONAL INJURY, WRONGFUL DEATH, DAMAGE TO PROPERTY, OR OTHERWISE RESULTING FROM MY PARTICIPATION IN THE PROGRAM AND/OR THE ACTS OF OMISSIONS OF ANY OF CROSSFIT NEW HAVEN PARTIES, INCLUDING ANY AND ALL NEGLIGENT ACTS, WHETHER ACTIVE OR PASSIVE, IRRESPECTIVE OF WHETHER SUCH INJURIES, DEATH, OR DAMAGES OCCURE DURING TRAINING OR THEREAFTER.

\_\_\_\_\_ I HAVE CAREFULLY READ THIS RELEASE AND FULLY UNDERSTAND ITS CONTENTS. I AM AT LEAST 18 YEARS OF AGE. I AM AWARE THAT THIS IS A RELEASE OF LIABILITY AND A CONTRACT BETWEEN ME AND CROSSFIT NEW HAVEN AND I SIGN IT OF MY OWN FREE WILL.

Executed on \_\_\_\_\_, \_\_\_\_\_ at \_\_\_\_\_, Connecticut.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Phone Number

**CrossFit New Haven**

1175 State St., Unit 207, New Haven, CT 06511

**HEALTH HISTORY INFORMATION:**

NAME: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

\_\_\_\_\_  
AGE: \_\_\_\_\_

\_\_\_\_\_  
GENDER: MALE/FEMALE \_\_\_\_\_

PHONE#: (HOME) \_\_\_\_\_ EMAIL: \_\_\_\_\_

(CELL) \_\_\_\_\_ POSITION: \_\_\_\_\_

(WORK) \_\_\_\_\_ COMPANY: \_\_\_\_\_

**Please answer the following questions:**

Diagnosed hypercholesterolemia (total cholesterol greater than 200mg/dl or HDL less than 35 mg/dl) **YES OR NO** **TOTAL CHOLESTEROL #** \_\_\_\_\_

Diagnosed hypertension (blood pressure greater than or equal to 140/90 mg/dl) **YES OR NO**

Any smoking habits? **YES OR NO**

Any past history? **YES OR NO**

Diabetes? (adult or juvenile) **YES OR NO**

Any family history of heart disease prior to the age of 55? **YES OR NO**

Any drinking habits? (alcohol)? **YES OR NO**

How much? \_\_\_\_\_

WOMEN: Are you 55 years of age or older? **YES OR NO**

MEN: Are you 45 years of age or older? **YES OR NO**

List any medications or allergies: \_\_\_\_\_

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List any and all surgeries, illnesses or injuries (ortho) that you have had or have:

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When was your last physical check up? \_\_\_\_\_

**Please answer the following questions (please specify)**

**Any heart/vascular problems:**

- \_\_\_\_\_ Heart disease, heart attack, angina
- \_\_\_\_\_ Coronary angioplasty/cardiac surgery
- \_\_\_\_\_ Rapid heartbeats/palpitations
- \_\_\_\_\_ Heart murmurs or unusual cardiac findings
- \_\_\_\_\_ Peripheral vascular disease
- \_\_\_\_\_ Stroke
- \_\_\_\_\_ Other

**Any metabolic disease:**

- \_\_\_\_\_ kidney disease
- \_\_\_\_\_ thyroid disorders
- \_\_\_\_\_ liver disorders

**Any respiratory disease:**

- \_\_\_\_\_ Asthma
- \_\_\_\_\_ Chronic bronchitis
- \_\_\_\_\_ Emphysema
- \_\_\_\_\_ Other

Any shortness of breath \_\_\_\_\_

Unusual fatigue \_\_\_\_\_

Ankle swelling \_\_\_\_\_

Chest discomfort at rest or during exertion \_\_\_\_\_

Faint or dizziness \_\_\_\_\_

***I verify that all information notes above are accurate. I understand that it is my responsibility to update the staff of CrossFit New Haven of any changes in my medical status and it is also my responsibility to obtain medical clearance from my physician if needed to participate in my personal training program.***

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Signature of Participant

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Date

**CrossFit New Haven**

*1175 State St., Unit 207, New Haven, CT 06511*

**EMERGENCY CONTACT FORM**

NAME: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

**EMERGENCY CONTACT IN CASE OF AN ACCIDENT:**

NAME OF CONTACT PERSON \_\_\_\_\_

PHONE# (HOME) \_\_\_\_\_ (WORK) \_\_\_\_\_

RELATIONSHIP TO CLIENT \_\_\_\_\_

NAME OF CONTACT PERSON \_\_\_\_\_

PHONE# (HOME) \_\_\_\_\_ (WORK) \_\_\_\_\_

RELATIONSHIP TO CLIENT \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_

**ARE YOU ALLERGIC TO ANYTHING:**

\_\_\_\_\_  
\_\_\_\_\_

**ARE YOU TAKING ANY MEDICATIONS AT THE PRESENT TIME:**

\_\_\_\_\_  
\_\_\_\_\_

**CHOICE OF HOSPITAL YOU WOULD LIKE TO BE TAKEN:** \_\_\_\_\_

**WHAT TYPE OF INSURANCE DO YOU HAVE:**

\_\_\_\_\_

\_\_\_\_\_  
**SIGNATURE OF CLIENT**

\_\_\_\_\_  
**DATE**