



Times Colonist Health Club Challenge Application Form

APPLICANT INFORMATION

<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.	First Name: _____	Birth Date:	_____	_____	_____	F <input type="checkbox"/> M <input type="checkbox"/> Gender
	Last Name: _____	MM	DD	YY	Age	
Municipality: _____		Address: _____				
Mobile Phone #: _____		Home Phone#: _____		Work Phone #: _____		
Email: _____		May we email you TC Health Club At Home Challenge information? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Occupation/Employer: _____						
Medical Alert (if none, note N/A): _____		WHAT IS YOUR GOAL OF BEING PART OF THE 2012 TIMES COLONIST HEALTHCLUB CHALLENGE?				
ARE YOU PREPARED TO COMMIT TO A FITNESS PROGRAM 3X PER WEEK, FOR 12 WEEKS? <input type="checkbox"/> Yes <input type="checkbox"/> No ARE YOU PREPARED TO MAKE MAJOR LIFESTYLE CHANGES AS ADVISED BY OUR EXPERTS? <input type="checkbox"/> Yes <input type="checkbox"/> No ARE YOU PREPARED TO FOLLOW A MEAL PLAN DESIGNED BY OUR NUTRITION CONSULTANT? <input type="checkbox"/> Yes <input type="checkbox"/> No ARE YOU PREPARED TO SHARE PERSONAL INFORMATION ABOUT YOURSELF FOR THE TC ARTICLES? <input type="checkbox"/> Yes <input type="checkbox"/> No (this may include weight, body fat %, and other items that showcase your progress throughout the program)						

APPLICANT HEALTH INFORMATION (Must be completed)

Please read the questions below carefully and answer each one honestly. Check YES or NO.

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	1. Have you ever been diagnosed with a heart condition and been told that your physical activity should be regulated by a doctor?
<input type="checkbox"/>	<input type="checkbox"/>	2. When you do physical activity do you feel chest pains?
<input type="checkbox"/>	<input type="checkbox"/>	3. Have you had chest pain in the last month when you were doing physical activity?
<input type="checkbox"/>	<input type="checkbox"/>	4. Have you ever felt dizziness, lost consciousness or had poor balance?
<input type="checkbox"/>	<input type="checkbox"/>	5. Do you have previous problems with bones or joints that would be worsened during physical activity?
<input type="checkbox"/>	<input type="checkbox"/>	6. Are you taking any prescription medication for blood pressure or a heart condition?
<input type="checkbox"/>	<input type="checkbox"/>	7. Are you aware of ANY OTHER REASON why you should not participate in physical activity?

PLEASE NOTE: If you've answered **Yes** to any of the above questions, has your Doctor since cleared you for physical activity? If yes, please provide date: _____; If **NO**, then for your own health and safety, please contact your doctor to receive authorization **BEFORE** you start becoming more physically active or **BEFORE** you have a fitness appraisal.

