

Fairfax County Government Employee & Retiree Member Registration

FACILITY HOURS:

Monday—Friday: 5am—7pm

Closed on weekends and ALL Fairfax County Government Holidays

Fitness Director: Chuck Wright

GYM RATES

Membership Type <i>(Please Circle One)</i>	One Month Rates	Three Month Rates
County Gov't Employees & Retirees	\$15	\$40
Legal Spouses & Adult Dependents	\$15	\$40
Locker room use ONLY	\$5	\$15
Daily Drop-In Fee	\$3	

Name (Last, First) _____

Home/Cell # _____ Work # _____

Address _____

City _____ State _____ Zip _____

Birthday _____ Department _____

Email Address _____

Emergency Contact _____ Phone # _____ Relationship _____

Fairfax County Government Employee ID is required for New Enrollment & Subsequent Renewal



Questions or more information about EFWC: 703-324-5590



ADA Accommodations: 703-324-3311

EFWC Membership Policy

Open to all employees, dependents, and retirees of Fairfax County Government

Members of the EFWC may choose one person over 18 years of age who live in the same household for them to join the EFWC.

For more information, please inquire at the front desk.

Starting Monday, January 1st, 2024, the Employee Fitness & Wellness Center will be changing our renewal process.

Membership and drop-in fees can be paid by credit/ debit card or check.

We do not accept American Express or Cash.

Payments are due in a timely manner. If you have forgotten your payment the day it is due and want to use the facility, you will be charged a \$3 drop-in fee per visit, for up to 3 visits post-expiration which will be added to your renewal total. A 4th visit will result in refusal from the facility until balance is cleared.

Thank you for your cooperation and valued membership.

By signing below, I affirm that I have read and understand the above statements and hereby agree to the terms and conditions stated above.

Signature

Exercise Program Informed Consent

I, _____, acknowledge that entering into an exercise program is designed to improve my personal fitness. I understand that in undertaking this exercise program made available through the Fairfax County Employee Fitness and Wellness Center (hereafter known as "EFWC"), some risk may be involved, and I fully assume that risk.

I understand and am aware that strength and aerobic exercise are potentially hazardous activities. I further understand that fitness activities may involve a risk of musculoskeletal injury and even death. I am voluntarily participating in these activities using equipment and machinery with knowledge of the dangers involved. I hereby agree to expressly assume and accept any and all risks of injury or death. I further acknowledge gym activity entirely voluntary event and any medical issues which may arise from it will not be considered work related.

I do hereby declare myself physically sound and suffering from no condition, impairment, disease, infirmity, or illness that would prevent my safe participation or use of equipment except hereinafter stated.

I understand that any fitness evaluation performed by Fairfax County EFWC personnel is not a substitute in any way for a diagnostic evaluation by my physician and is solely used to establish baseline fitness parameters in order to develop my exercise program. I have been informed of the need for a physician's approval for my participation in exercise-related activity, and the use of fitness room equipment.

I have read and understand this form in its entirety and do hereby waive, release, and forever discharge Fairfax County Government, the EFWC, and its officers, agents, employees and representatives, executors, and all others from any responsibilities or liabilities from injuries or damage resulting from my participation in any activities or my use of equipment or machinery in the above-mentioned activities.

Employee's Printed Name Employee's Signature Date

Witness (LiveWell Staff) Printed Name Witness Signature Date

Short Health History Questionnaire

Please complete the following prior to beginning your exercise program and in ink only.

Please answer the following questions:

	YES	NO
Date of last physical: _____		
Are you over 65 and NOT accustomed to vigorous exercise?	_____	_____
Do you frequently have pain in your chest?	_____	_____
Do you often feel faint or have spells of severe dizziness?	_____	_____
Has a doctor ever told you that you have a bone or joint problem, such as arthritis, that has been aggravated by exercise?	_____	_____
Has your doctor ever said that you have heart trouble?	_____	_____
Is there a good physical reason, not mentioned here, as to why you should not follow an activity program, even if you wanted to?	_____	_____

Please be advised that a YES answer to any of the above questions may prevent us from developing an exercise program for you without a completed physician's medical clearance. The Fitness Director will let you know if a medical clearance is necessary.

Please select ALL known health conditions:

- | | | |
|--|---|--|
| <input type="checkbox"/> Chest Discomfort | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Coronary Bypass | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Current Heart Murmur | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Skipped/Rapid Heartbeat | <input type="checkbox"/> Knee Problems | <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Limited Joint ROM | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Lupus | <input type="checkbox"/> Previous Heat Stroke |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Neck Problems | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Vision Impairment |
| <input type="checkbox"/> Phlebitis or Emboli | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Shoulder Problems | <input type="checkbox"/> Other (please specify): |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Swollen, sore, or painful joints | _____ |
| <input type="checkbox"/> Ankle Swelling | <input type="checkbox"/> Allergies | _____ |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Asthma | _____ |
| <input type="checkbox"/> Broken Bones (recent) | <input type="checkbox"/> Bronchitis | |
| <input type="checkbox"/> Foot Problems | <input type="checkbox"/> Pneumonia | |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Pulmonary Edema | |