



JamiesonPlace

Jamieson Place Fitness Centre Pre-Authorized Payment Plan



Membership No
Name
Home Address
City/Province
Postal Code
Home Telephone
Business Telephone

I/we authorize Jamieson Place Fitness Centre and/or Health Systems Group Limited to charge monthly dues to my/our bank account or credit card. Jamieson Place Fitness Centre is authorized to change the amount of the monthly payment by giving the member 60 days written notice of the change. Failure on the part of the member to advise in writing of his/her disagreement with the change within 30 days of the written notice of change, shall be deemed to be full acceptance of such change (Initial: _____)

I/we agree to notify Jamieson Place Fitness Centre and/or Health Systems Group Limited in writing within 10 days of any change in my/our bank or credit card account. (Initial: _____)

All authorized charges are to be made on or after 15th day of each month. If any of my bank or credit card debits does not clear or is not honored by my financial institution, for any reason, I authorize Jamieson Place Fitness Centre or Health Systems Group Limited to charge against the supplied credit card or pre-authorized chequing to the amount refused or dishonored plus a \$20.00 NSF administration fee. (Initial: _____)

This authorization may be cancelled at any time upon written notice, to the Jamieson Place Fitness Centre or Health Systems Group Limited, by me/us (cancellation deadline is the **20th of each month** to be effective for month-end). (Initial: _____)

- Pre Authorized Chequing Payment
- Void Cheque Attached
- Pre Authorized Credit Card Payment

Type	Name on Card (please print)	Card #	Expiry
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Signature:
Signature:
Date:

For a joint account, all depositors must sign, if more than one signature is required on cheques issued against the account.



JamiesonPlace

JAMIESON PLACE FITNESS CENTRE

INFORMED CONSENT AND AGREEMENT AND RELEASE FORM

For participation in all activities at Jamieson Place Fitness Centre

Please read carefully before signing.

Date: _____

Thank you for choosing to use the activities, facilities, programs or services of Jamieson Place Fitness Centre. We request your understanding and cooperation in maintaining your safety and health by reading and signing the following INFORMED CONSENT AND AGREEMENT AND RELEASE FORM.

I, **(PLEASE PRINT)** _____ declare that I intend to use some or all of the activities, facilities, programs and services (hereinafter called “Activities”) offered by Jamieson Place Fitness Centre. I assume full responsibility for my health and well being during and after my participation in such Activities and for my choices to use or apply at my own risk any portion of the information or instruction I receive.

I understand that part of the risk involved in undertaking any of the Activities is relative to my own state of fitness or health (physical, mental or emotional) and to the awareness, care and skill with which I conduct myself in any of the Activities of Jamieson Place Fitness Centre. In addition, I understand that I am free to withdraw from, reduce or modify my involvement in any of the Activities and I realize that I should do so on recognition of any signs of physical discomfort, which may include: light-headedness, fainting, chest pain or discomfort, leg cramps, nausea, etc.

I, for myself, my heirs, executors, and administrators, release and forever discharge Jamieson Place Fitness Centre, HSG Health Systems Group Ltd., bcIMC Realty Corporation and QuadReal Property Group LP and each of their successors and assigns and each of their affiliates, directors, officers, employees, agents, member instructors and independent contractors (collectively called the “Released Parties”) from any claims, actions, costs, expenses and demands in respect of death, injury, loss or damage to my person or property (including without limitation, under the Occupiers’ Liability Act) wherever or however caused, including, without limitation, the negligence of one or more of the Released Parties, arising out of or in connection with the use or intended use of Jamieson Place Fitness Centre.

I consent to taking all of the above noted and other risks by VOLUNTARILY PARTICIPATING in all and any fitness programs, which may or may not be designed and implemented by a qualified fitness consultant employed by Jamieson Place Fitness Centre: _____ **(PLEASE INITIAL)**.

I declare that I have read, understood and agree to the contents of this INFORMED CONSENT AGREEMENT & RELEASE FORM in its entirety, and I have signed it voluntarily.

Signature: _____ Witness: _____

Date: _____ Date: _____

(Adapted from Fitness Standards Safety Committee, “Safety Standards” from Screening of Participants Planning to Engage in Activities and Programs Offered by the Ontario Fitness Industry. Third draft, January 1989, p.7)



JAMIESON PLACE FITNESS CENTRE



MEMBERSHIP APPLICATION (for BP Centre Tenants)

MEMBERSHIP #		SECURITY CARD #		EFFECTIVE DATE	YY	MM	DD
NAME FIRST		LAST		DATE OF BIRTH	YY	MM	DD
HOME ADDRESS			EMAIL	HOME PHONE			
COMPANY NAME			WORK LOCATION (BLDG & FLOOR NO.)	BUSINESS PHONE			
EMERGENCY CONTACT NAME			RELATIONSHIP	EMERGENCY CONTACT PHONE			

SHADED AREAS FOR OFFICE USE ONLY

CHECK APPROPRIATE BOX(es) BELOW:

- NEW MEMBER
- RENEWING MEMBERSHIP
- Employee
- Contractor
- Student

MONTHLY FEE
PRO-RATED FEE
REJOINING ADMIN FEE
INITIAL PAYMENT

****ONLY full-time occupants of BP Centre will be permitted to join Jamieson Place Fitness Centre**

CANCELLATION: Cancellation notification must be received no later than the 20th of the month to be effective for month-end. There is a four (4) month minimum membership term. Tenants must pay a \$50.00 administration fee to rejoin.

PRIVACY: Jamieson Place Fitness Centre is committed to protecting personal information by following responsible information handling practices in accordance with the provisions of the Personal Information Protection Act (PIPA) of Alberta. The member hereby gives permission for the Jamieson Place Fitness Centre or its nominees, associates, and affiliates or their employees, to collect any personal information contained in this document, maintain personal information already on file and to collect further information for the purpose of contacting the member by mail, fax, telephone and/or email.

I understand and agree to the above. _____ (initial)

PAYMENT AUTHORIZATION

I hereby authorize the Jamieson Place Fitness Centre to collect membership fees, by pre-authorized chequing or credit card payment, at the current rate. Rates may be adjusted in subsequent years with notice posted in the Jamieson Place Fitness Centre 30 days in advance. I have read and understood the terms and conditions of membership.

SIGNATURE	DATE	YY	MM	DD
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PLEASE RETURN APPLICATION **INTACT** TO THE JAMIESON PLACE FITNESS CENTRE
INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED

AUTHORIZED SIGNATURE	DATE	YY	MM	DD
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PAR-Q+

The Physical Activity Readiness Questionnaire for Everyone

Regular physical activity is fun and healthy, and more people should become more physically active every day of the week. Being more physically active is very safe for MOST people. This questionnaire will tell you whether it is necessary for you to seek further advice from your doctor OR a qualified exercise professional before becoming more physically active.

SECTION 1 - GENERAL HEALTH

Please read the 7 questions below carefully and answer each one honestly: check YES or NO.		YES	NO
1.	Has your doctor ever said that you have a heart condition OR high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Do you feel pain in your chest at rest, during your daily activities of living, OR when you do physical activity?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Do you lose balance because of dizziness OR have you lost consciousness in the last 12 months? Please answer NO if your dizziness was associated with over-breathing (including during vigorous exercise).	<input type="checkbox"/>	<input type="checkbox"/>
4.	Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Are you currently taking prescribed medications for a chronic medical condition?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Do you have a bone or joint problem that could be made worse by becoming more physically active? Please answer NO if you had a joint problem in the past, but it does not limit your current ability to be physically active. For example, knee, ankle, shoulder or other.	<input type="checkbox"/>	<input type="checkbox"/>
7.	Has your doctor ever said that you should only do medically supervised physical activity?	<input type="checkbox"/>	<input type="checkbox"/>

If you answered NO to all of the questions above, you are cleared for physical activity.



Go to Section 3 to sign the form. You do not need to complete Section 2.

- › Start becoming much more physically active – start slowly and build up gradually.
- › Follow the Canadian Physical Activity Guidelines for your age (www.csep.ca/guidelines).
- › You may take part in a health and fitness appraisal.
- › If you have any further questions, contact a qualified exercise professional such as a CSEP Certified Exercise Physiologist® (CSEP-CEP) or CSEP Certified Personal Trainer® (CSEP-CPT).
- › If you are over the age of 45 yrs. and NOT accustomed to regular vigorous physical activity, please consult a qualified exercise professional (CSEP-CEP) before engaging in maximal effort exercise.



If you answered YES to one or more of the questions above, please GO TO SECTION 2.



Delay becoming more active if:

- › You are not feeling well because of a temporary illness such as a cold or fever – wait until you feel better
- › You are pregnant – talk to your health care practitioner, your physician, a qualified exercise professional, and/or complete the PARmed-X for Pregnancy before becoming more physically active OR
- › Your health changes – please answer the questions on Section 2 of this document and/or talk to your doctor or qualified exercise professional (CSEP-CEP or CSEP-CPT) before continuing with any physical activity programme.

SECTION 2 - CHRONIC MEDICAL CONDITIONS

Please read the questions below carefully and answer each one honestly: check YES or NO.		YES	NO
1.	Do you have Arthritis, Osteoporosis, or Back Problems?	<input type="checkbox"/> If yes, answer questions 1a-1c	<input type="checkbox"/> If no, go to question 2
1a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)	<input type="checkbox"/>	<input type="checkbox"/>
1b.	Do you have joint problems causing pain, a recent fracture or fracture caused by osteoporosis or cancer, displaced vertebra (e.g., spondylolisthesis), and/or spondylolysis/pars defect (a crack in the bony ring on the back of the spinal column)?	<input type="checkbox"/>	<input type="checkbox"/>
1c.	Have you had steroid injections or taken steroid tablets regularly for more than 3 months?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Do you have Cancer of any kind?	<input type="checkbox"/> If yes, answer questions 2a-2b	<input type="checkbox"/> If no, go to question 3
2a.	Does your cancer diagnosis include any of the following types: lung/bronchogenic, multiple myeloma (cancer of plasma cells), head, and neck?	<input type="checkbox"/>	<input type="checkbox"/>
2b.	Are you currently receiving cancer therapy (such as chemotherapy or radiotherapy)?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Do you have Heart Disease or Cardiovascular Disease? This includes Coronary Artery Disease, High Blood Pressure, Heart Failure, Diagnosed Abnormality of Heart Rhythm	<input type="checkbox"/> If yes, answer questions 3a-3e	<input type="checkbox"/> If no, go to question 4
3a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)	<input type="checkbox"/>	<input type="checkbox"/>
3b.	Do you have an irregular heart beat that requires medical management? (e.g. atrial brillation, premature ventricular contraction)	<input type="checkbox"/>	<input type="checkbox"/>
3c.	Do you have chronic heart failure?	<input type="checkbox"/>	<input type="checkbox"/>
3d.	Do you have a resting blood pressure equal to or greater than 160/90 mmHg with or without medication? (Answer YES if you do not know your resting blood pressure)	<input type="checkbox"/>	<input type="checkbox"/>
3e.	Do you have diagnosed coronary artery (cardiovascular) disease and have not participated in regular physical activity in the last 2 months?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Do you have any Metabolic Conditions? This includes Type 1 Diabetes, Type 2 Diabetes, Pre-Diabetes	<input type="checkbox"/> If yes, answer questions 4a-4c	<input type="checkbox"/> If no, go to question 5
4a.	Is your blood sugar often above 13.0 mmol/L? (Answer YES if you are not sure)	<input type="checkbox"/>	<input type="checkbox"/>
4b.	Do you have any signs or symptoms of diabetes complications such as heart or vascular disease and/or complications affecting your eyes, kidneys, and the sensation in your toes and feet?	<input type="checkbox"/>	<input type="checkbox"/>
4c.	Do you have other metabolic conditions (such as thyroid disorders, pregnancy-related diabetes, chronic kidney disease, liver problems)?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Do you have any Mental Health Problems or Learning Difficulties? This includes Alzheimer's, Dementia, Depression, Anxiety Disorder, Eating Disorder, Psychotic Disorder, Intellectual Disability, Down Syndrome)	<input type="checkbox"/> If yes, answer questions 5a-5b	<input type="checkbox"/> If no, go to question 6
5a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)	<input type="checkbox"/>	<input type="checkbox"/>
5b.	Do you also have back problems affecting nerves or muscles?	<input type="checkbox"/>	<input type="checkbox"/>

Please read the questions below carefully and answer each one honestly: check YES or NO.		YES	NO
6.	Do you have a Respiratory Disease? This includes Chronic Obstructive Pulmonary Disease, Asthma, Pulmonary High Blood Pressure	<input type="checkbox"/> If yes, answer questions 6a-6d	<input type="checkbox"/> If no, go to question 7
6a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)	<input type="checkbox"/>	<input type="checkbox"/>
6b.	Has your doctor ever said your blood oxygen level is low at rest or during exercise and/or that you require supplemental oxygen therapy?	<input type="checkbox"/>	<input type="checkbox"/>
6c.	If asthmatic, do you currently have symptoms of chest tightness, wheezing, laboured breathing, consistent cough (more than 2 days/week), or have you used your rescue medication more than twice in the last week?	<input type="checkbox"/>	<input type="checkbox"/>
6d.	Has your doctor ever said you have high blood pressure in the blood vessels of your lungs?	<input type="checkbox"/>	<input type="checkbox"/>
7.	Do you have a Spinal Cord Injury? This includes Tetraplegia and Paraplegia	<input type="checkbox"/> If yes, answer questions 7a-7c	<input type="checkbox"/> If no, go to question 8
7a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)	<input type="checkbox"/>	<input type="checkbox"/>
7b.	Do you commonly exhibit low resting blood pressure significant enough to cause dizziness, light-headedness, and/or fainting?	<input type="checkbox"/>	<input type="checkbox"/>
7c.	Has your physician indicated that you exhibit sudden bouts of high blood pressure (known as Autonomic Dysreflexia)?	<input type="checkbox"/>	<input type="checkbox"/>
8.	Have you had a Stroke? This includes Transient Ischemic Attack (TIA) or Cerebrovascular Event	<input type="checkbox"/> If yes, answer questions 8a-c	<input type="checkbox"/> If no, go to question 9
8a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)	<input type="checkbox"/>	<input type="checkbox"/>
8b.	Do you have any impairment in walking or mobility?	<input type="checkbox"/>	<input type="checkbox"/>
8c.	Have you experienced a stroke or impairment in nerves or muscles in the past 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
9.	Do you have any other medical condition not listed above or do you live with two chronic conditions?	<input type="checkbox"/> If yes, answer questions 9a-c	<input type="checkbox"/> If no, read the advice on page 4
9a.	Have you experienced a blackout, fainted, or lost consciousness as a result of a head injury within the last 12 months OR have you had a diagnosed concussion within the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
9b.	Do you have a medical condition that is not listed (such as epilepsy, neurological conditions, kidney problems)?	<input type="checkbox"/>	<input type="checkbox"/>
9c.	Do you currently live with two chronic conditions?	<input type="checkbox"/>	<input type="checkbox"/>

Please proceed to Page 4 for recommendations for your current medical condition and sign this document.

PAR-Q+



If you answered NO to all of the follow-up questions about your medical condition, you are ready to become more physically active:

- › It is advised that you consult a qualified exercise professional (e.g., a CSEP-CEP or CSEP-CPT) to help you develop a safe and effective physical activity plan to meet your health needs.
- › You are encouraged to start slowly and build up gradually – 20-60 min. of low- to moderate-intensity exercise, 3-5 days per week including aerobic and muscle strengthening exercises.
- › As you progress, you should aim to accumulate 150 minutes or more of moderate-intensity physical activity per week.
- › If you are over the age of 45 yrs. and NOT accustomed to regular vigorous physical activity, please consult a qualified exercise professional (CSEP-CEP) before engaging in maximal effort exercise.



If you answered YES to one or more of the follow-up questions about your medical condition:

- › You should seek further information from a licensed health care professional before becoming more physically active or engaging in a fitness appraisal and/or visit a or qualified exercise professional (CSEP-CEP) for further information.



Delay becoming more active if:

- › You are not feeling well because of a temporary illness such as a cold or fever – wait until you feel better
- › You are pregnant - talk to your health care practitioner, your physician, a qualified exercise professional, and/or complete the PARmed-X for Pregnancy before becoming more physically active OR
- › Your health changes - please talk to your doctor or qualified exercise professional (CSEP-CEP) before continuing with any physical activity programme.

SECTION 3 - DECLARATION

- › You are encouraged to photocopy the PAR-Q+. You must use the entire questionnaire and NO changes are permitted.
- › The Canadian Society for Exercise Physiology, the PAR-Q+ Collaboration, and their agents assume no liability for persons who undertake physical activity. If in doubt after completing the questionnaire, consult your doctor prior to physical activity.
- › If you are less than the legal age required for consent or require the assent of a care provider, your parent, guardian or care provider must also sign this form.
- › Please read and sign the declaration below:

I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. I also acknowledge that a Trustee (such as my employer, community/fitness centre, health care provider, or other designate) may retain a copy of this form for their records. In these instances, the Trustee will be required to adhere to local, national, and international guidelines regarding the storage of personal health information ensuring that they maintain the privacy of the information and do not misuse or wrongfully disclose such information.

NAME _____ DATE _____

SIGNATURE _____ WITNESS _____

SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER _____

**For more information, please contact:
Canadian Society for Exercise Physiology
www.csep.ca**

KEY REFERENCES

1. Jamnik VJ, Warburton DER, Makarski J, McKenzie DC, Shephard RJ, Stone J, and Gledhill N. Enhancing the effectiveness of clearance for physical activity participation; background and overall process. APNM 36(S1):S3-S13, 2011.
2. Warburton DER, Gledhill N, Jamnik VK, Bredin SSD, McKenzie DC, Stone J, Charlesworth S, and Shephard RJ. Evidence-based risk assessment and recommendations for physical activity clearance; Consensus Document. APNM 36(S1):S266-s298, 2011.

The PAR-Q+ was created using the evidence-based AGREE process (1) by the PAR-Q+Collaboration chaired by Dr. Darren E. R. Warburton with Dr. Norman Gledhill, Dr. Veronica Jamnik, and Dr. Donald C. McKenzie (2). Production of this document has been made possible through financial contributions from the Public Health Agency of Canada and the BC Ministry of Health Services. The views expressed herein do not necessarily represent the views of the Public Health Agency of Canada or BC Ministry of Health Services.

With regard to the provisions of the Privacy Act, I hereby give my permission for HSG Health Systems Group Limited to collect any personal information contained in this document, maintain personal information already on file and to collect further information for the purpose of contacting me by mail, fax, telephone and/or email.

NAME:
SIGNATURE:

DATE: