ATHLETIC PERFORMANCE CENTER
OF EXETER HOSPITAL

Registration Form

Please submit in person, email: apcenter@ehr.org

Client Information			
Last Name:	First:	Middle:	DOB:
Street Address:			
City:	State:	Zip Code:	
Home Phone:	Cell Phone:	Email Address:	
Emergency Contact Name/Number/Relationship:			
Current Health Concerns:		How did you hear about us?	

Program Sign-up (Please Circle)		
Adult Fitness	Surf/Rugby Fit	Foundation
Complete Athlete	Elite Athlete	Vert
Solo Training	Small Group Training	Post Rehabilitation
Team Training	Complete Athletic Evaluation	Nutritional Consultation

Athletic Performance Center of Exeter Hospital Acknowledgement and Disclosure Form

Physical exercise and sports performance training can be strenuous and subject you to the risk of injuries, including but not limited to strains, sprains, lacerations and contusions. As a result, the Athletic Performance Center of Exeter Hospital urges you (or, as applicable, your minor child or ward) to obtain a physical examination from a doctor before using any exercise equipment or participating in any training activity and use due care when engaging in exercise and sports performance training.

In signing this form you acknowledge your fitness and ability (or, as applicable, that of your minor child or ward) to engage in physical exercise and sports performance training and the risks involved in doing so. Your signature also indicates that you have accurately reported your (or, as applicable, your minor child's or ward's) past medical history and any current injuries and physical limitations you (or, as applicable, your minor child or ward) might have.

By signing this form, you also acknowledge that we are also not responsible for any loss of personal property on the premises. We encourage you to secure personal property in the lockers provided.

By signing this from, I acknowledge that I understand its content and that this document cannot be modified.	
SIGNED (If for a minor child or ward, parent or legal guardian – circle which)	x
PRINTED NAME (and, as applicable, that of your minor child or ward)	x

Referral Program		
For every 1 person you refer & is converted you receive 10% off your program rate!		
Name:	Phone:	Email:
Name:	Phone:	Email:
Name:	Phone:	Email:

APC will respect and protect this information and will not share without the clients discretion

Employee Purposes Only		
Program:	Price:	Payment Method:
Start Date:	End Date:	