REGIONAL THERAPY CENTER
A SERVICE OF SARATOGA HOSPITAL

Health & Fitness Gym
6 Care Lane
Saratoga Springs, NY 12866
518-583-8383

Member Information

Last Name First Name MI _____ Age Date of Birth _____

Street address _____ City State, Zip _____

Home Phone Cell Phone e-mail address _____

Emergency contact _____ Relationship to member _____

Address _____ Phone(s) _____

I would like to be a member of the Health and Fitness Gym and I agree to the rules and responsibilities of membership.

Signature _____ Date _____

Staff Signature _____ Date _____

Staff Use Only:

After Therapy Club: Y N Visit by Visit___ If yes, physician clearance is provided and dated: _____

Member ID # _____ Fit Blue #_____ Card copied____

Initial prorated month fee _____ Membership Type: 3 mo___ 6 mo___ Expiration date:_____
Month by month: CC-auto___ EFT-auto___ Check/Cash___

Initial payment method: Check # _____ SH Receipt #_____ (Check made out to: Saratoga Hospital)

Cash SH Receipt #_____ Credit Card SH Receipt #_____