

# Community Fitness Program Registration Form

## Member Information

First Name

Last Name

Mailing Address

City

State

Zip Code

Community Area

Phone

Fax

Email

Date

T-shirt Size    Small\_\_\_    Medium\_\_\_    Large\_\_\_    XL\_\_\_    2XL\_\_\_

## Questions

Did you get a doctors approval to take part in the fitness program?    Yes\_\_\_    No\_\_\_

Are you a University of Chicago Medicine Patient?    Yes\_\_\_    No\_\_\_

What is the name of the doctor or healthcare provider who referred you to the fitness program?

How did you hear about the fitness program?

## Any other needs you may have

## Emergency Contact Information

Contact Name

Phone

**Member's Signature:** \_\_\_\_\_

**Please, Only Mail or Fax This Form**

**Mail:** 950 East 61<sup>st</sup> Street, Room 223, Chicago, IL 60637

**Fax:** (773) 702-3193

**For more information call or e-mail:** (773) 702-5600    [outreach@uchospitals.edu](mailto:outreach@uchospitals.edu)



**THE UNIVERSITY OF  
CHICAGO MEDICINE**

Urban Health Initiative

AT THE FOREFRONT OF BUILDING HEALTHY COMMUNITIES™

## For Office Use Only

**Member ID** \_\_\_\_\_

**Date** \_\_\_\_\_