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 61st Street, Room 223, Chicago, IL 60637
Fax: (773) 702-3193
For more information call or e-mail: (773) 702-5600 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_____