



MEMBERSHIP APPLICATION FORM

I wish to apply for membership at City Rise Hotel Fitness Centre. I understand that any false information submitted will result in the automatic disqualification of my application.

Please fill in all necessary details in Section A, B, C D, & E. It is important that the medical questionnaire is completed and signed as well as the terms and conditions of application.

The minimum age of members is 6 to 17 years old (Under 18 years old is required to sign Parental Consent Form)

For adults, 18 years old and above.

IMPORTANT NOTICE

City Rise Hotel Fitness Centre strictly complies with the Personal Data Protection Act 2010 ("Act") in processing and safeguarding personal data. By signing this form, you consent to your personal and sensitive information being processed under the rules of the Act.

City Rise Hotel Fitness Centre ensures all information is confidential and securely stored. We may contact you for marketing purposes.

☐ If you do not wish to be contacted, please tick this box

SECTION A - PERSONAL INFORMATION

Name of Applicant as in IC or passport:

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I/C or Passport No.: Nationality:

Gender: Male / Female

Contact No: (O) (H) (Mobile)

Designation/Position/Profession:

Employer's Name & Address:

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Residential Address:

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SECTION B - EMERGENCY CONTACT

Contact Name: Home No:

Relationship: Mobile No:

SECTION C: MEDICAL BACKGROUND

Exercising is an essential part of maintaining a healthy lifestyle. It is important that the following question answered fully and honestly to enable us to ensure that members can exercise safely.

i) Have you, for any reason, been unable to exercise in the past 3 years?

☐ Yes ☐ No

ii) Has your doctor ever advised you against exercising?

☐ Yes ☐ No

iii) Have you ever suffered from any cardiac (heart) related illness?

☐ Yes ☐ No

- iv) Have you ever suffered from respiratory difficulties?
☐ Yes ☐ No
- iv) Have you ever suffered from respiratory difficulties?
☐ Yes ☐ No
- v) Have you suffered from fainting, migraines or loss of balance?
☐ Yes ☐ No
- vi) Is there any history of heart disease in your family?
☐ Yes ☐ No
- vii) Have you experienced chest pain whilst exercising?
☐ Yes ☐ No
- viii) Do you have high blood pressure?
☐ Yes ☐ No
- ix) Do you have elevated cholesterol levels?
☐ Yes ☐ No
- x) Are you currently taking prescribed medication?
☐ Yes ☐ No
- xi) Have you ever gone for medical check up in the last 1 months?
☐ Yes ☐ No

If you answered "YES" to any of the above, please give details below. All information is held strictest confidence and accessible only by the relevant Fitness in-charge.

Your Doctor's Details:

Doctor's Name:

Hospital/Clinic Name: Hospital/Clinic Contact No.

SECTION D - MEMBERSHIP DURATION

☐ 1 Month ☐ 12 Months

Membership Start Date:

SECTION E - CONFIRMATION

I, (Mr./ Mrs./ Miss/Mdm) (IC)
, the undersigned, certify that the above information is correct and acknowledged that any false information submitted will result in the automatic disqualification of my application.

Applicant's Signature:

Date:

Select your preferred membership type:

E-Membership Card ☐
Physical Membership card ☐
Both ☐