Membership Info

Memberships

A registration fee for each continuous membership period plus an all inclusive monthly fee allow you city-wide access to all four P&G Fitness Centers. **There are no long-term contracts typical of commercial fitness clubs**

How to Join

Join online at pgfitness.trihealth.com. Once complete, an email will be sent outlining the remaining steps to start your membership. The online joining option helps streamline the process allowing you to start at your convenience.

Join in person - Complete the Health Profile, Informed Consent (eight-digit personnel number or driver license number for non-P&G employee spouse or domestic partner required) and call the Fitness Center to set up a 15 minute registration and prescreening. Bring a payment method for the registration fee.

For your safety, if you do not meet P&G medical guidelines based on the review of your Health Profile, then a Physician Consent Form may be requested, prior to participation.

Fees
GO/MBC/F&HCIC/WHBC

Registration fee*
$24.82 Per Person

Monthly Fee*
$23.99 Single
$39.99 Dual Membership

*all prices plus tax

All P&G Cincinnati full/part-time employees, co-ops, interns, retirees and spouse/ domestic partners are eligible to join. The monthly fees can be automatically deducted via credit card, bank draft or by payroll deduction.

Any questions you may have regarding membership at the Fitness Centers, please call any of the numbers listed below or visit our web site.

F&HCIC ····· 627-8888
MBC ·········· 622-3488
GO ·········· 983-9999
WHBC ···· 634-3488

Facility Hours

F&HCIC & MBC
Monday - Thursday*
5:30am - 8:00pm
Friday
5:30am - 7:00pm
GO & WHBC
Monday - Thursday*
5:00am - 8:00pm
Friday
5:00am - 7:00pm
WHBC -Saturday
8:00am-2:00pm

*Memorial Day-Labor Day All sites close at 7:30pm Monday -Thursdays.
WHBC-Closed Saturdays.

We observe all P&G holidays. All hour changes will be posted in advance.

Peak Hours
6:00am - 8:00am
11:00am - 12:30pm
4:30pm - 6:00pm

Mobile App

Everything needed to connect with your fitness center account.

Search:

TriHealth Fitness Center

pgfitness.trihealth.com

Member Services

Complimentary Personal Training Services: All members can choose from the following complimentary Personal Training Menu as part of their base membership!

Session #1 - Personalized Fitness Assessment: One of our trainers will take you through a series of exercise tests including the BODPOD to assess your current level of fitness. Specific exercise recommendations, following the American College of Sports Medicine guidelines, will be discussed based upon assessment results, personal goals and interests. (Approx. 60 minutes).

Session #2 - Personalized Program Design: One of our trainers will meet with you and design a personal fitness program based upon your goals and interests. They will take you step-by-step though your first workout (Approx. 60 minutes).

Session #3 - Program Follow-Up: One of our trainers will meet with you in week 4 to review your program, answer questions, and make appropriate progressions to keep you progressing towards your goals (Approx. 30 minutes).

Session #4 - Program Progression: Vary your exercise program to avoid boredom and plateaus. Meet with one of our trainers around month 3 to change your routine and keep your body/muscles surprised and constantly adapting. (Approx. 60 minutes).

Ongoing Program Monitoring: One of our trainers will monitor your participation and send you motivational messages as well as fitness tips to help keep you on track.

Online scheduling available at pgfitness.trihealth.com

Fee-for-Service Appointments:

- **Personal Training Services** - Multiple session personal training services are available on a fee-for-service basis. Fees are based upon the number of sessions purchased. Ask one of our staff members about ongoing personal training services and package options, or call the Personal Training Coordinator, at 983-9999.
- **Massage Therapy Services** - Available on a fee-for service basis. Fees are based upon the length of the session purchased. Everyone can benefit from a professional massage. Massage can provide anything from soothing relaxation to deeper therapy for specific physical problems; relieve symptoms of stress and anxiety; increase the nourishing blood supply to your tissues and many other things. Provided currently at GO, FHCIC, MBC and WHBC. Schedule online or call ahead for appointment - hour and half-hour appointments are available.
- **Pilates Reformer** - An exercise system designed to transform the way your body looks, feels and performs. Available in group or private sessions.

Membership Amenities:

- **Towel Service** – We provide workout and shower towels for your convenience.
- **Secure Lockers** – Daily use lockers are provided in the locker rooms.
- **Shower Essentials** – Shampoo, conditioner, body soaps, shower towels, hair dryers are provided in the locker rooms.
- **Incentive Programs** – Programs geared towards performing activities and gaining points for an individual/team. These programs also raise awareness to various types of training & exercises.

Complimentary BODPOD Assessment:

The BODPOD Gold Standard Body Composition Tracking System is an air displacement plethysmograph, which uses whole body densitometry to determine body composition (fat and fat free mass).

BODPODs are located at our Winton Hill, GO, and MBC locations for your convenience. **You can schedule online at pgfitness.trihealth.com** or call the P&G Fitness Centers to schedule your BODPOD assessment today.

GO: 983-9999
WHBC: 634-3488
MBC: 622-3488

Body composition assessments are not recommended more than once per quarter; therefore, testing is limited to four times per year.

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MEMBERSHIP INFORMATION & HEALTH PROFILE

HOW DID YOU HEAR ABOUT US? (PLEASE CHECK ONE)

Building Tour		Café Display		CO-Worker/Friend		Email		Flyers		Wired	
I'm a Previous Member		Intern Coordinator		New Hire Orientation		Other:					

Employee Name: Email: ❑Male ❑Female

Employee Personnel Number: ___ ___ ___ ___ ___ ___ ___ ___ T#____________ Date of Birth______/_____/_____ Age_____

Employee Referred by Name: Email:

HOME ADDRESS: CITY: STATE: ZIP: PHONE (_____) _____ - _______

P&G WORK LOCATION: PHONE (_____) _____ - _______

EMPLOYEE/RETIREE PHYSICIAN NAME PHONE (_____) _____ - _______

EMPLOYEE/RETIREE EMERGENCY CONTACT PHONE (_____) _____ - _______

Do you currently have any of the following?

Employee

- Y N Hypercholesterolemia (total cholesterol greater than 200 mg/dL or HDL less than 35 mg/dL)
- Y N Hypertension, blood pressure greater than or equal to 140/90 mmHg, or on hypertensive medication
- Y N Smoking habit (current)
- Y N Diabetes
- Y N **WOMEN:** Are you 55 yrs of age or older?
- Y N **WOMEN:** Had a baby weighing > 9 lbs.?
- Y N **MEN:** Are you 45 years of age or older?

Staff Use Only
1. BMI $\geq$ 30 kg/m^2
2. < 65 yrs. old and minimal exercise (<90 min/wk.)
3. **3.** > 45 yrs old

How many days per week do you get moderate to intense physical activity such as a brisk walk? __________
How many minutes per day do you perform activities such as this? _________

Staff Use Only
1. Inactive Less than 90 minutes/Week

For staff use 2

Do you have a history of any of the following diseases?

- Y N Heart disease, heart attack, angina
- Y N Coronary angioplasty/cardiac surgery
- Y N Rapid heartbeats (greater than 100bpm)/palpitations
- Y N Heart murmurs or unusual cardiac findings
- Y N Peripheral vascular disease
- Y N Stroke
- Y N Other heart/vascular problems (specify) ______________________
- Y N Asthma
- Y N Chronic bronchitis
- Y N Emphysema or COPD
- Y N Other respiratory problems (specify) ______________________
- Y N Thyroid or metabolic disorder
- Y N Diabetes
- Y N Kidney disease
- Y N Cancer
- Y N Other diagnosed disease/disorder (specify) ______________________

Do you have a history of the following signs or symptoms?

- Y N Fainting or dizziness
- Y N Chest discomfort at rest or during exertion
- Y N Unusual fatigue or shortness of breath
- Y N Pregnancy (current or within 2 months postpartum)
- Y N Major surgery/hospitalization/rehabilitation/illness within the past 6 months

Please Specify: ______________________

For staff use 1

Do you have a history of any of the following?

- Y N Orthopedic problems (joint/bone) within the past 6 months
  Specify ______________________
- Y N Chronic back problems Specify______________________
- Y N Arthritis Specify______________________

List all medications you are taking.

	MEDICATION	REASON
1)	____________	____________
2)	____________	____________
3)	____________	____________

Do you have any other medical situations or physical limitations, which should be considered prior to your participation in an exercise program?

No____ Yes_____if yes, please explain ______________________

For staff use 1

Select the statement that best describes your level of stress over the last 6 months:

________No stress ________ Occasional mild stress ________Frequent mild/moderate ________Constant high stress

I verify all information noted above is accurate and I understand it is my responsibility to update the fitness staff of any changes in health status, which would alter my ability to safely participate in a fitness program.

Signature: ______________________ **Date:** ___/___/______

For staff use: BP ____/_____ HR ________ Height ________ Weight _________ BMI ________ BF% ________
Staff _________ **PCF required:** ▢yes ▢ no Risk Assessment: DLR___ DMR___ DMHR___ DHR___ LR___ MR___ MHR___ HR___
Date: _____/_____/_____ © 2010 Bethesda Healthcare, Inc. All rights reserved. Copying or reproducing this document is strictly prohibited

P&G FITNESS CENTER
INFORMED CONSENT AND WAIVER
FOR FITNESS CENTER PARTICIPATION

As a participant in the **P&G Fitness Center**, fitness screenings and/or exercise activities, I understand and I have been informed that my **voluntary participation** in health promotion and fitness programs and special events including, but not limited to, the use of weights, number of repetitions and use of any and all machinery, equipment, all apparatus designed for exercising and the associated **facilities shall be the participant's sole responsibility** during all times of Fitness Center use. I also understand and have been informed that participation in any of the events noted above **does pose the risk of serious injury or other adverse health consequences, including death.** I agree to **self-limit my exertion through good judgment** and to **terminate any physical activity immediately, if it exceeds my personal limitations,** whether or not it exceeds the activity level recommended by the staff or prescribed by my physician. I hereby consent to, and permit emergency medical treatment in the event of any injury or illness.

If requested to obtain written consent from a personal physician, **I verify** that I have been **evaluated by a physician,** and I have been approved to participate in the programs and exercise activities as stipulated on my Physician Consent Form which is attached. If my current fitness status limits my activities, it has been indicated on my Physician Consent Form. These **limitations** have been **fully explained to me, and I understand and assume the risk** of injury and other adverse health consequences, including death, if I exceed the exercise and dietary guidelines recommended by my physician.

I understand it is my **responsibility** to seek and to continue to **receive medical evaluations** from my personal physician to determine if there are any medical conditions or injuries that could limit my participation in fitness or health promotion activities. **I agree to notify the staff of changes** in health status, physical injuries, pregnancy, hospitalizations, surgery or additional physical and medical limitations, or additions/changes in medication recommended by my physician that may affect my participation in fitness or health promotion activities. I understand that for any new medical conditions or injuries noted above, **written consent from my personal physician** may be **required prior to resuming** activities. I understand my activities may be modified.

In consideration for my participation in fitness programs, special events, and exercise activities, **I voluntarily assume the risk** of any injury, loss and/or adverse health consequence. I, for myself, my heirs, executors, administrators and assignees, hereby **release TriHealth, Inc., Bethesda Healthcare, Inc.,** and their officers, directors, employees and their affiliated entities from any and all claims, liabilities or demands of any kind arising from any injury, loss or adverse health consequence, including death, related to my participation in fitness or health promotion activities, except to the extent resulting from its or their negligence or willful misconduct.

Subject to these conditions, I affirm that I have read, understand and agree to the terms set forth above and I wish to participate in fitness and /or health promotion programs, exercise activities and special events.

Name (Print): ____
print

Signature: ____ ***Date:*** _____/_____/_____
member/spouse/domestic partner signature

Witness: ____
staff signature

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Spouse/DP MEMBERSHIP INFORMATION & HEALTH PROFILE

HOW DID YOU HEAR ABOUT US? (PLEASE CHECK ONE)

Building Tour		Café Display		CO-Worker/Friend		Email		Flyers		Wired	
I'm a Previous Member		Intern Coordinator		New Hire Orientation		Other:					

Spouse Domestic Partner
Name: **Email:** ❑Male ❑Female

Spouse Domestic Partner
Drivers License/Personnel Number: ___ ___ ___ ___ ___ ___ ___ ___ **T#**___________ **Date of Birth**______/_____/______ **Age**____

HOME ADDRESS: **CITY:** **STATE:** **ZIP:** **PHONE** (_____) _____ - _______

Spouse Domestic Partner
Referred by Name: **Email:**

PHYSICIAN NAME **PHONE** (_____) _____ - _______

EMERGENCY CONTACT **PHONE** (_____) _____ - _______

Do you currently have any of the following?

Spouse

Y N Hypercholesterolemia (total cholesterol greater than 200 mg/dL or HDL less than 35 mg/dL)
Y N Hypertension, blood pressure greater than or equal to 140/90 mmHg, or on hypertensive medication
Y N Smoking habit (current)
Y N Diabetes
Y N **WOMEN:** Are you 55 yrs of age or older?
Y N **WOMEN:** Had a baby weighing > 9 lbs.?
Y N **MEN:** Are you 45 years of age or older?

Staff Use Only
1. BMI $\geq$ 30 kg/m^2
2. < 65 yrs. old and minimal exercise (<90 min/wk.)
3. > 45 yrs old

How many days per week do you get moderate to intense physical activity such as a brisk walk? __________
How many minutes per day do you perform activities such as this? _________

Staff Use Only
1. Inactive Less than 90 minutes/Week

For staff use 2

Do you have a history of any of the following diseases?

Y N Heart disease, heart attack, angina
Y N Coronary angioplasty/cardiac surgery
Y N Rapid heartbeats (greater than 100bpm)/palpitations
Y N Heart murmurs or unusual cardiac findings
Y N Peripheral vascular disease
Y N Stroke
Y N Other heart/vascular problems (specify)
____
Y N Asthma
Y N Chronic bronchitis
Y N Emphysema or COPD
Y N Other respiratory problems (specify)
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Y N Kidney disease
Y N Cancer
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Y N Major surgery/hospitalization/rehabilitation/illness within the past 6 months
Please Specify: _______________________________________

For staff use 1

Do you have a history of any of the following?

Y N Orthopedic problems (joint/bone) within the past 6 months
Specify ______________________________
Y N Chronic back problems Specify____________________
Y N Arthritis Specify______________________________

List all medications you are taking.

	MEDICATION	REASON
1)	______________________________	____________________
2)	______________________________	____________________
3)	______________________________	____________________

Do you have any other medical situations or physical limitations, which should be considered prior to your participation in an exercise program?
No____ Yes_____if yes, please explain _______________________________________

For staff use 1

Select the statement that best describes your level of stress over the last 6 months:
________No stress ________ Occasional mild stress ________Frequent mild/moderate ________Constant high stress

I verify all information noted above is accurate and I understand it is my responsibility to update the fitness staff of any changes in health status, which would alter my ability to safely participate in a fitness program.

Signature: ____ **Date:** ____/____/______

For staff use: BP ____/____ HR _______ Height _______ Weight ________ BMI _______ BF% _______
Staff _________ **PCF required:** □yes □ no Risk Assessment: DLR___ DMR___ DMHR___ DHR___ LR___ MR___ MHR___ HR___
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I understand it is my **responsibility** to seek and to continue to **receive medical evaluations** from my personal physician to determine if there are any medical conditions or injuries that could limit my participation in fitness or health promotion activities. **I agree to notify the staff of changes** in health status, physical injuries, pregnancy, hospitalizations, surgery or additional physical and medical limitations, or additions/changes in medication recommended by my physician that may affect my participation in fitness or health promotion activities. I understand that for any new medical conditions or injuries noted above, **written consent from my personal physician** may be **required prior to resuming** activities. I understand my activities may be modified.

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Subject to these conditions, I affirm that I have read, understand and agree to the terms set forth above and I wish to participate in fitness and /or health promotion programs, exercise activities and special events.

Name (Print): ____
print

Signature: ____ ***Date:*** _____/_____/_____
member/spouse/domestic partner signature

Witness: ____
staff signature

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