



Membership Information

Facility Hours

Monday – Friday
6:30am – 6:30pm
Monday – Friday

F&HCIC 513-627-8888

GO 513-983-9999

MBC 513-622-3488

WHBC 513-634-3488

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

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 GO, MBC, and WHBC locations for your convenience. **You can schedule by emailing pgfitness@trihealth.com.**

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



Memberships

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

Registration Fee*

\$24.82 Per Person

Monthly Fee*

\$23.99 Single

\$16.00 Spouse/Domestic Partner

BRB*

\$11.99

*all prices plus tax

Membership Amenities:

- **Towel Service** – We provide workout and shower towels for your convenience.
- **Secure Lockers** – Daily use lockers are provided in the locker room.
- **Shower Essentials** – Shampoo, Conditioner, body soaps, shower towels, and hair dryers are provided in the locker rooms.
- **Health and Fitness Challenges** – To increase motivation, exercise adherence, and promote a healthy lifestyle the P&G Vibrant Living Fitness Center's offer monthly challenges.

*All amenities & or services may not be available at BRB.

How to Join

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 stop in the fitness center to complete 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.

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 or bank draft.

Any questions you may have regarding membership please email pgfitness@trihealth.com or call one of the four fitness centers.



Vibrant Living
Fitness Center
Work us in... We'll work you out

MEMBERSHIP INFORMATION & HEALTH PROFILE

How did you hear about us? (Please check one)

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

Employee Name:	Email Address:	__ male __ female
Employee Personnel Number	T#	Date of Birth ___/___/___ Age:
Home Address:	City:	State: Zip: Phone:
P&G Work Location:		Phone:
Physician Name:		Phone:
Emergency Contact:		Phone:

Do you currently have any of the following?

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)	Staff use only 2 of 3 1. BMI ≥ 30 kg/m ² 2. <65 yrs. old and minimal exercise (<90 min/wk) 3. >45 yrs old
Y	N	Diabetes	
Y	N	Women: Are you 55 years of age or older?	
Y	N	Women: Had a baby weighing > 9 lbs.?	
Y	N	Men: Are you 45 years of age or older?	

How many days per week do you get moderate or intense physical activity such as a brisk walk? _____ **Staff Use Only**

How many minutes per day do you perform activities such as this? _____ 1. Inactive- less than 90 mins/wk

For staff use 2

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

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

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

Y	N	Asthma	Y	N	Fainting or dizziness
Y	N	Chronic bronchitis	Y	N	Chest discomfort at rest or during exertion
Y	N	Emphysema or COPD	Y	N	Unusual fatigue or shortness of breath
Y	N	Other respiratory problems (specify)	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

<p>Do you have a history of any of the following?</p> <p>Y N Orthopedic problems (joint/bone) within the past 6 months Specify _____</p> <p>Y N Chronic back problems Specify _____</p> <p>Y N Arthritis Specify _____</p> <p>Do you have another other medical situations or physical limitations, which should be considered prior to your participation in an exercise program? No ___ Yes ___ if yes, please explain _____</p>	<p>List all the medications you are taking.</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 70%;">Medication</th> <th style="width: 30%;">Reason</th> </tr> </thead> <tbody> <tr> <td>1. _____</td> <td>_____</td> </tr> <tr> <td>2. _____</td> <td>_____</td> </tr> <tr> <td>3. _____</td> <td>_____</td> </tr> </tbody> </table>	Medication	Reason	1. _____	_____	2. _____	_____	3. _____	_____
Medication	Reason								
1. _____	_____								
2. _____	_____								
3. _____	_____								

For staff use 1

Membership Type			
____ Employee Membership	____ Dual Employee Membership	____ Retiree Membership	____ Dual Retiree Membership

I verify all information 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: ___/___/___

**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 Physical Consent Form which is attached. If my current fitness status limits my activities, it has been indicated on my Physical 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 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 assuming 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 affiliates entities from any and all claims, liabilities or demands of any kind arising from an 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 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: _____
member/spouse/domestic partner signature

Date: ____/____/____

Witness: _____
staff signature

