



**THE LEAGUE**  
 FOR PEOPLE WITH DISABILITIES, Inc.  
*Putting Ability First*

# Membership Application

OFFICE USE ONLY	
Membership Type:	_____
Initiation Fee:	_____
Pro-Rated Amount:	_____
First Payment:	_____
Total Payment:	_____
Starting Date:	_____
Expire Date:	_____
Staff:	_____
Barcode ID:	_____

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH
			— —
ADDRESS		E-MAIL ADDRESS	CELL PHONE NUMBER
			— —
			HOME TELEPHONE NUMBER
			— —
CITY	STATE	ZIP CODE	WORK TELEPHONE NUMBER
			— —
EMERGENCY CONTACT		RELATIONSHIP	EMERGENCY CONTACT TELEPHONE NUMBER
			— —
NATURE OF DISABILITY			
<hr/> <hr/> <hr/>			
HAS YOUR PHYSICIAN IMPOSED ANY RESTRICTIONS?		IF YES, PLEASE EXPLAIN:	
<input type="radio"/> YES <input type="radio"/> NO		<hr/> <hr/> <hr/>	
HAVE YOU BEEN A MEMBER BEFORE?		IF YES, WHEN:	
<input type="radio"/> YES <input type="radio"/> NO		<hr/> <hr/> <hr/>	
HOW DID YOU HEAR ABOUT OUR FACILITY?			
<input type="radio"/> PHYSICIAN <input type="radio"/> FRIEND <input type="radio"/> OTHER LEAGUE PROGRAM <input type="radio"/> PHYSICAL THERAPIST <input type="radio"/> FRONT SIGN <input type="radio"/> OTHER: _____			

**THE FOLLOWING INFORMATION IS BEING REQUESTED TO GATHER STATISTICAL DATA FOR REPORTING TO THE UNITED WAY OF CENTRAL MARYLAND. YOUR INFORMATION WILL BE HELD IN STRICTEST CONFIDENCE AND WILL ONLY BE USED TO DETERMINE HOW THE LEAGUE CAN BETTER SERVE YOU AND MAINTAIN FUNDING BY THE UNITED WAY.**

RESIDENCY	SEX	PRIMARY SECONDARY	RACE	HOUSEHOLD INCOME
<input type="radio"/> I AM A CITY RESIDENT? <input type="radio"/> I AM A COUNTY RESIDENT?  IF COUNTY RESIDENT, NAME: _____	<input type="radio"/> MALE  <input type="radio"/> FEMALE	<input type="radio"/> <input type="radio"/> AFRICAN / AMERICAN <input type="radio"/> <input type="radio"/> ASIAN <input type="radio"/> <input type="radio"/> CAUCASIAN <input type="radio"/> <input type="radio"/> HISPANIC / LATINO <input type="radio"/> <input type="radio"/> NATIVE AMERICAN		<input type="radio"/> \$0 - \$15,000 <input type="radio"/> \$15,001 - \$30,000 <input type="radio"/> \$30,001 - \$50,000 <input type="radio"/> \$50,001 - Over

**VOLUNTEER OPPORTUNITIES**

ARE YOU (AND YOUR FAMILY) WILLING TO VOLUNTEER?     YES     NO

AREA OF INTEREST: \_\_\_\_\_

(Note: Volunteer Coordinator will contact you)

**WAIVER**

I UNDERSTAND THAT THE LEAGUE FOR PEOPLE WITH DISABILITIES, INC. ASSUMES NO RESPONSIBILITY FOR INJURIES OR ILLNESSES WHICH I MAY SUSTAIN AS A RESULT OF MY PHYSICAL CONDITION OR RESULTING FROM MY PARTICIPATION IN AN EXERCISE PROGRAM, THE USE OF ANY EQUIPMENT, OR OTHER ACTIVITIES. I EXPRESSLY ACKNOWLEDGE ON BEHALF OF MYSELF AND MY HEIRS OR CLIENTS THAT I ASSUME THE RISK FOR ANY AND ALL INJURIES AND ILLNESSES WHICH MAY RESULT FROM MY PARTICIPATION IN THESE ACTIVITIES. I HEREBY RELEASE AND DISCHARGE THE LEAGUE, ITS AGENTS, ASSIGNS AND/OR EMPLOYEES FROM ANY AND ALL CLAIMS FOR INJURY, ILLNESS, DEATH, LOSS OR DAMAGE WHICH I MAY SUFFER AS A RESULT OF MY PARTICIPATION IN THESE ACTIVITIES.

I UNDERSTAND THAT THE LEAGUE IS NOT RESPONSIBLE FOR PERSONAL PROPERTY LOST OR STOLEN WHILE MEMBERS AND/OR PROGRAM PARTICIPANTS ARE USING THE LEAGUE FACILITIES OR ON THE LEAGUE PREMISES.

\_\_\_\_\_  
PRIMARY MEMBER SIGNATURE

\_\_\_\_\_  
DATE

**INFORMED CONSENT AND RELEASE – NO PHYSICIAN'S REFERRAL FORM**

I HEREBY STATE THAT I AM NOT DISABLED AND AM JOINING THE LEAGUE'S PROGRAM WITHOUT SPECIAL CONSULTATION WITH MY PHYSICIAN(S).

\_\_\_\_\_  
PRIMARY MEMBER SIGNATURE

\_\_\_\_\_  
DATE

THE LEAGUE FOR PEOPLE WITH DISABILITIES, INC.  
 FITNESS & AQUATIC CENTER  
 1111 E. COLD SPRING LANE  
 BALTIMORE, MARYLAND 21239  
 TELEPHONE: (410) 323-0500 EXT. 314    FAX: (410) 323-3298

(REVISED 7/20/10)