Please fill out form completely. Print as many copies as needed for each participating member of your Household/Workplace.

APPLICATION FORM

go! for it!

Household/Workplace Name:

Individual's Name:

Have you experienced any pain or discomfort in your chest, dizziness or felt lightheaded during physical activity in the last 6 months? ☐ YES ☐ NO

If yes, please consult your physician before proceeding.

Do you have a medical condition that may affect your ability to be physically active? ☐ YES ☐ NO

If yes, please consult your physician before proceeding.

Has a health care provider told you that you should avoid or modify certain types of physical activity? ☐ YES ☐ NO

If yes, please consult your physician before proceeding.

Date of Birth (must be minimum age of 18 as of June 1, 2019)

Address:

Community:

First Name:

Last Name:

Phone:

Cell:

Email:

Gender: ☐ Female ☐ Male ☐ Other

Why do you want to be a part of this program?

My current level of physical activity:

- ☐ Over 150 minutes of moderate to vigorous activity per week
- ☐ Fewer than 150 minutes of moderate to vigorous activity per week
- ☐ No activity

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