



City of Murray



VOLUNTARY WELLNESS PROGRAM

FITNESS FACILITY MEMBERSHIP REIMBURSEMENT FORM **(Employee and Dependent)**

Name: _____
(Print)

Department: _____

I wish to participate in the fitness facility membership reimbursement program that is being offered to participants of the voluntary wellness program of the City of Murray. I understand that the reimbursement program is for monthly membership fees only, does not include enrollment or any other additional fees, is for employees and their eligible dependents only, and will reimburse a maximum of \$50 per month as long each participant meets the minimum requirement of eight (8) visits per month at an approved fitness facility. If any eligible participant fails to meet the minimum requirement of eight (8) visits per month at an approved fitness facility, their monthly fees will not be received on the reimbursement check. I also understand that the fitness facility must be a facility that is recognized as a bona fide facility by the City of Murray Wellness Team.

I understand that with any physical activity, there are risks, including increased heart stress and the chance of musculoskeletal injuries. In volunteering to participate in this physical activity, I agree that, to my knowledge, I have no limiting physical conditions or disability that would preclude the physical activity.

A physician's examination is recommended for all participants with any exercise restrictions, including any heart problems, high blood pressure, chest pain, dizziness, relevant surgeries, diabetes, asthma, epilepsy, arthritis, or significant injury to any part of the body. By signing below, I accept full responsibility for my own health and well-being and I acknowledge an understanding that no responsibility is assumed by the City of Murray or its employees, authorized agents or assignees.

The City of Murray and its employees, authorized agents or assignees are released from any liability now or in the future for conditions that may result from participation in any City recreational activities including but not limited to: heart attacks, muscle strains, muscle pulls, muscle tears, broken bones, shin splints, heat exhaustion, injuries to the knees, injuries to the back, injuries to the feet, any complicated preexisting condition whether known or unknown, or any other illness or soreness that may occur, including death. I hereby indemnify, hold harmless, and forever discharge the City of Murray from all claims, demands, and causes of injury that may occur.

I hereby affirm that I have read and fully understand the above statements.

Employee participant signature

Date

Dependent participant signature

Date

Name of fitness facility: _____

Employee Monthly membership fee: _____ Dependent/Family Monthly membership fee: _____

Note: Receipt showing monthly fee must be attached.

*By signing above, I authorize the release of my monthly fitness facility attendance records to the City of Murray.
104 North 5th Street, Suite B, Murray, Kentucky 42071 TELEPHONE (270) 762-0350 FAX 270-762-0354*