



TRAINING PACKAGE PRICING

NAME: _____ DOB: _____ GENDER: _____

ADDRESS: _____ CITY: _____ STATE: _____

EMAIL: _____ PHONE: _____

For Office Use Only:

PAYMENT AMOUNT: _____

Cash _____ Check: _____

Credit: MASTERCARD VISA AMEX DISCOVER

Trainer Assigned: _____

Today's Date: _____

Staff Initials: _____

PLEASE CIRCLE THE PACKAGE YOU WOULD LIKE TO PURCHASE

| | Member | Student |
|--|--------------|--------------|
| Personal One on One Training | | |
| 1 Sessions | \$45 | \$25 |
| 3 Sessions | \$105 | \$65 |
| 5 Sessions | \$175 | \$115 |
| 10 Sessions | \$350 | \$200 |
| Buddy Training (Split the cost with a friend) | | |
| 3 Sessions | \$100 | \$80 |
| 5 Sessions | \$160 | \$120 |
| 10 Sessions | \$300 | \$220 |



PERSONAL TRAINING POLICIES

The Providence College **Personal Training Program** is available to all students and CFC members. Our **nationally certified** personal trainers can provide you with the education and instruction you will need to reach your **health** and **fitness goals**. You can meet with a certified personal trainer, **one-on-one** or with a **buddy**. Your Personal Trainer will design and guide you through a **personalized** fitness regimen. Sessions are one hour in length.

SCHEDULING:

To schedule your initial session:

1. Complete Interest Form, Health History Questionnaire, and Policies forms and return when you schedule your pay for your package.
2. Register and pay for package at the Concannon/Peterson Office Monday through Friday 8:30am – 4:30pm.
3. Schedule your training sessions by calling or emailing Susan Gibree (401) 865-2350 sgaber@providence.edu

***All scheduling, rescheduling or cancellation of Personal Training Services should be done through the Fitness Director, Susan Gibree at (401) 865-2350.**

CANCELLATION/RESCHEDULING POLICY

If you need to cancel or reschedule a session, please call Susan Gibree at (401) 865-2350.

If she is not in, be sure to leave her a message. She will check the availability of your trainer and get back to you with confirmation of the rescheduled date and time. If it is a last minute emergency and you have your instructor's telephone number, please call the instructor directly.

24 hours' notice is required for cancellation or rescheduling to receive credit for the session. Failure to cancel within this time frame or failure to show up for a session will result in the client being charged for the session. Exceptions will only be made in the case of a medical emergency accompanied by a doctor's note.

****If you cancel more than three times without 24 hours' notice we reserve the right to terminate the remainder of your personal training sessions.***

TARDINESS POLICY:

Clients are expected to begin working out at the start time of the scheduled appointment. A late start time does not entitle a client to a session longer than the scheduled appointment.

I verify that I understand and will abide by these policies

Client Signature _____ Date _____



Name (Please Print) _____ Phone # _____

Date of Birth ___/___/___ Height _____ Weight _____ Gender M F

Emergency Contact (Please Print): _____ Phone # _____

BOX 1

Do you have a history of the following?

- YES / NO Heart attack
- YES / NO Heart surgery
- YES / NO Cardiac catheterization
- YES / NO Coronary angioplasty (PTCA)
- YES / NO Pacemaker / implantable cardiac defibrillator / rhythm disturbance
- YES / NO Heart valve disease
- YES / NO Heart failure
- YES / NO Heart transplant
- YES / NO Congenital heart disease

Do you have any of the following symptoms?

- YES / NO You experience chest discomfort with exertion
- YES / NO You experience unreasonable breathlessness
- YES / NO You experience dizziness, fainting, blackouts
- YES / NO You take heart medications

BOX 2

Please mark ALL true statements

- _____ You are a male older than 45 years
- _____ You are a woman older than 45 years or you have had a hysterectomy or you are post- menopausal
- _____ You smoke
- _____ Your blood pressure is greater than 140 / 90
- _____ You take blood pressure medication
- _____ You have a close blood relative who had a heart attack before age 55 (father or brother) or age 65 (mother or sister)
- _____ You are diabetic or take medication to control your blood pressure



- You are physically inactive (i.e. you get less than 30 minutes of physical activity on at least 3 days/week)
- You are 20 pounds or more overweight
- You have been diagnosed with kidney disease
- You have been diagnosed with thyroid or other endocrinological disorder
- You have respiratory problems, such as asthma, chronic bronchitis, emphysema or COPD
- You have muscular problems
- You have arthritis or other orthopedic problems or have had a previous injury
- You are pregnant

BOX 3

Please mark ALL true statements

- I do not know my blood pressure
- I do not know my cholesterol level

List all medications you take on a regular basis:

| Medication | Reason |
|-------------------|---------------|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |
| 4. _____ | _____ |

Other Comments/Health Issues?



I understand that I may be undergoing physical exertion while participating in services and activities at or associated with the Concannon/Peterson Fitness and Recreation Center and I certify that my level of physical fitness is sufficient for the activities in which I choose to take part. In acknowledging that I am aware of and willing to assume the risks associated with these activities and services, I hereby voluntarily agree to waive, hold harmless and indemnify Providence College and its agents, volunteers and employees from any and all claims, demands, damages and causes of action of any nature whatsoever arising out of ordinary negligence which I, my heirs, my assigns or successors may have against them for, on account of, or by reason of my voluntary participation in services and activities at or associated with Providence College and Recreation Center. I understand the content of this document, and I execute this INFORMED CONSENT AND WAIVER OF CLAIM FORM of my own free will and accord.

YES / NO I have read and understood the questions asked. I verify that all the information noted above is accurate to the best of my knowledge.

Name of Participant (Print): _____

Signature of Participant: _____ Date: _____

Signature of Parent or Guardian: _____ Date: _____



PERSONAL TRAINING INTEREST FORM

Availability: (this is not final)

| | Sun | Mon | Tue | Wed | Thu | Fri | Sat |
|-------|-----|-----|-----|-----|-----|-----|-----|
| 6:00 | | | | | | | |
| 7:00 | | | | | | | |
| 8:00 | | | | | | | |
| 9:00 | | | | | | | |
| 10:00 | | | | | | | |
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| 11:00 | | | | | | | |

For administrative use only:

Trainer assigned: _____

Date: _____