



Visit Pass Application

First Name _____ Surname _____

Address _____

Suburb _____ Postcode _____

Email _____

Phone Number _____ Mobile _____

Occupation _____

Date of Birth ____ / ____ / ____

Gender Male Female

How did you find out about us? _____

Emergency Contact

Name **X** _____ Phone _____

Number of Visits

10 visits 20 visits 50 visits First visit taken Yes No

Conditions

This visit pass entitles the above mentioned to use The Gap Health & Racquet Club's facilities on a casual basis for the number of visits purchased. These visits must be used within 12 months of the date purchased.

Please read the following and sign as recognition of the following terms:

By signing below, I advise The Gap Health & Racquet Club that I am physically capable and have no medical condition that will endanger my health by using the facilities of The Club. In the case of an existing medical condition, I confirm that I have received medical advice permitting me to use the facilities at The Club and advising that my condition will not endanger my health or that of others.

By signing below, I acknowledge that I will not hold The Club liable for any personal injury or damage or loss of my property while I am on The Club's premises.

I also acknowledge that The Gap Health & Racquet Club reserves the right to either refuse my entry or terminate my visits if my actions or behaviour are considered dangerous to myself or others on The Club's premises. By signing, I agree to abide by The Club's rules and regulations.

Signed **X** _____ Date _____

(If under 18 years of age a parent or guardian must sign) Staff Member _____

Office Use Only

Membership Type Single Couple Adult Student

Start Date ____ / ____ / ____ Amount Paid _____ Cash Cheque Credit Card Eftpos

Assessment Yes No Date ____ / ____ / ____ Time _____ Consultant _____

Processed by _____ Date _____

Comments _____