



MEMBERSHIP FORM:	
Membership Start Date: ___/___/___ Membership Expiry Date: ___/___/___	
Membership Term	
Monthly:	<input type="checkbox"/>
6 Month:	<input type="checkbox"/>
Annual:	<input type="checkbox"/>
Name:	
First Name:	Surname:
Date of Birth:	
Gender:	
Male:	<input type="checkbox"/>
Female:	<input type="checkbox"/>
Address:	
Full Address:	
Contact Information	
Primary Contact Information:	
Email Address:	@
Emergency Contact Number:	
Additional Information	
How did you find out about Total Health Zone?	
Word of Mouth:	<input type="checkbox"/>
Press/Brochure:	<input type="checkbox"/>
Internet/Email:	<input type="checkbox"/>
Other Channels:	<input type="checkbox"/>
Have you used a Gym before?	
Yes:	<input type="checkbox"/>
No:	<input type="checkbox"/>

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Membership Fees	
I agree to pay the following fees: Joining Fee \$_____	
Gym Subscription	
Monthly: <input type="checkbox"/>	6 Month: <input type="checkbox"/> Annual: <input type="checkbox"/>
Fee: \$_____	
TOTAL FEE: \$_____	
Signature: _____ Date: __/__/__	
Declaration	
Before signing this document, I have read, understand and hereby agree to the terms and conditions of Membership, and acknowledge that it may affect my legal rights.	
Signature: _____ Date: __/__/__	

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