



**Nina B. Hollis Wellness Center  
Faculty/Staff Membership Form**

Date and Time: \_\_\_\_\_ Faculty  Staff  Dept: \_\_\_\_\_

Faculty/Staff Member Name: \_\_\_\_\_ ID# \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell# \_\_\_\_\_ e-mail address: \_\_\_\_\_

*Family Members:*

Spouse's Name: \_\_\_\_\_ DOB \_\_\_\_\_ ID# \_\_\_\_\_

Intramurals \$25.00/acad. yr.

Children age 15 or older: (Under 15 for Pool usage only)

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ ID# \_\_\_\_\_

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ ID# \_\_\_\_\_

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ ID# \_\_\_\_\_

**Emergency Contact:**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

**I declare that I have read and understand the policies and information provided within this packet and that the above named persons are members of my immediate family, currently residing full-time in my home and the address listed above is their only place of residence.**

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Office Use Only**

Staff: \_\_\_\_\_ Total Paid: \_\_\_\_\_ Date Paid: \_\_\_\_\_

Cash  Check  Charge: Type \_\_\_\_\_

Scanned to Advancement