Number:

Broadway Tech Flex

Email: techflex@curtishealth.com Phone: (604) 215-7324

Membership Form

Fee	Payment Options
☐ 1 Month Membership ($25.00) ☐ 3 Month Membership ($60.00) ☐ 6 Month Membership ($100.00) ☐ 1 Year Membership ($200.00) ☐ Monthly Auto-Pay Contract ($19.00 per month Visa/MasterCard) charged monthly, 6 months minimum 30 days cancellation notice	☐ Amex ☐ Visa ☐ Mastercard

The above membership rates include GST

☐ ***Please check to provide your consent to receive electronic communications regarding Fitness Centre updates including Group Fitness and Personal Training information and promotions, and upcoming events.***

Last Name: _____First Name: _____

Tenant Information

Company: _____ Security Card #_____

Email: _____ Telephone: _____

Emergency Contact Information

Contact Name: _____ Telephone: _____

For office Use Only: Term Length_____ Contract in Volo_____

Start Date (dd/mm/yy): _____ Expiry Date (dd/mm/yy): _____

Amount Collected: $_____ (including tax)
Amex_☐__Visa_☐__Mastercard _☐_Contract_☐__

Receipt/Invoice #: _____ Waiver to QuadReal_____

Excel: _____ Access: _____ PAR Q: _____ Welcome Letter: _____ Security Card: _____

1. I understand that my membership is for a minimum of 1 month.
2. Reasonable refund arrangements requested **in writing** one month in advance will be made for individuals whose employment contract may expire, their work location is transferred, or for those with a medical condition. Refunds will apply only to full months remaining.
3. I agree to abide by all rules and regulations set forth by TechFlex Fitness Centre

Date (dd/mm/yy):_____ **Signature:**_____

RELEASE OF LIABILITY, WAIVER OF CLAIMS
ASSUMPTION OF RISKS AND INDEMNITY AGREEMENT
BY SIGNING THIS DOCUMENT, YOU WILL WAIVE CERTAIN
LEGAL RIGHTS, INCLUDING THE RIGHT TO SUE
PLEASE READ CAREFULLY!

TO: Owners and Operators of Fitness facilities at The Broadway Tech Centre, including 2725312 Canada Inc., Broadway Tech Centre Holdings Inc., Canadian Core Real Estate LP and it's Agents, and Curtis Personalized Health Management Ltd. (Together, the 'COMPANY")

In this agreement, the term "FITNESS ACTIVITIES" shall mean weight lifting, weight training, aerobics and personal fitness or training activities of any kind and shall include all instruction, training, demonstrations and use of the COMPANY gymnasium equipment and facilities located at Broadway Tech Centre (the "FACILITIES").

ASSUMPTION OF RISKS

I am aware that FITNESS ACTIVITIES involve many risks, dangers and hazards including, but not limited to mounting, using and disembarking fitness or exercise equipment, moving, loading, lifting, securing and unloading free weights and other fitness equipment components; dropping free weights and other fitness equipment components; loss of control; entrapment; dehydration; over-exertion; fainting; muscle strain; angina; stroke; aneurysm; circulatory or respiratory problems; collision or contact with other fitness or exercise participants; failure to engage in FITNESS ACTIVITIES safely or within one's own ability or within designated areas; negligence of other persons participating in FITNESS ACTIVITIES on or about the FACILITIES; and **NEGLIGENCE ON THE PART OF THE COMPANY OR ITS AGENTS OR OTHER EMPLOYEES, INCLUDING THE FAILURE ON THE PART OF THE COMPANY OR ITS AGENTS OR OTHER EMPLOYEES TO SAFEGUARD OR PROTECT ME FROM THE RISKS, DANGERS AND HAZARDS OF FITNESS ACTIVITIES.**

I AM AWARE OF THE RISKS, DANGERS AND HAZARDS ASSOCIATED WITH FITNESS ACTIVIITES AND I FREELY ACCEPT AND FULLY ASSUME ALL SUCH RISKS, DANGERS AND HAZARDS AND THE POSSIBILITY OF PERSONAL INJURY, DEATH, PROPERTY DAMAGE AND LOSS RESULTING THEREFROM.

RELEASE OF LIABILITY, WAIVER OF CLAIMS AND INDEMNITY AGREEMENT

In consideration of THE COMPANY providing and permitting my use of the FACILITIES and other good and valuable consideration, the receipt and sufficiency of which is acknowledged, I hereby agree as follows:

1. **TO WAIVE ANY AND ALL CLAIMS that I have or may have in the future against THE COMPANY, and its directors, officers, employees, agents, representatives, successors and assigns, (all of whom are hereinafter collectively referred to as the "RELEASEES"), and to RELEASE THE RELEASEES from any and all liability for any loss, damage, expense or injury including death that I may suffer, or that my next of kin may suffer from either my use of or my presence on or about the FACILITIES DUE TO ANY CAUSE WHATSOEVER, INCLUDING NEGLIGENCE, BREACH OF CONTRACT, OR BREACH OF ANY STATUTORY OR OTHER DUTY OF CARE, INCLUDING ANY DUTY OF CARE OWED UNDER THE *OCCUPIERS LIABILITY ACT*, R.S.B.C. 1996, c.337, ON THE PART OF THE RELEASEES, AND ALSO INCLUDING THE FAILURE ON THE PART OF THE RELEASEES TO SAFEGUARD OR PROTECT ME FROM THE RISKS, DANGERS AND HAZARDS OF FITNESS ACTIVITIES REFERRED TO ABOVE.**
2. TO HOLD HARMLESS AND INDEMNIFY THE RELEASEES from any and all liability for any damage to property of or personal injury to any third party, resulting from my use of or presence on or about the FACILITIES;
3. This Agreement shall be effective and binding upon my heirs, next of kin, executors, administrators, assigns and representatives, in the event of my death or incapacity;
4. The Agreement shall be governed by and interpreted in accordance with the laws of the Province of British Columbia; and
5. Any litigation involving the parties to this Agreement shall be brought within the Province of British Columbia.

In entering into this Agreement, I am not relying upon any oral or written representations made by the RELEASEES with respect to the safety of FITNESS ACTIVITIES other than what is set for in this Agreement.

I HAVE READ AND UNDERSTAND THIS AGREEMENT AND I AM AWARE THAT BY SIGNING THIS AGREEMENT I AM WAIVING CERTAIN LEGAL RIGHTS WHICH I OR MY HEIRS, NEXT OF KIN, EXECUTORS, ADMINISTRATORS, ASSIGNS AND REPRESENTATIVES MAY HAVE AGAINST THE RELEASEES.

Name:(Print)	Date (D/M/Y)	Signature	Date of Birth (D/M/Y)	Witness
_____	__/__/__	_____	__/__/__	_____

2020 PAR-Q+

The Physical Activity Readiness Questionnaire for Everyone

The health benefits of regular physical activity are clear; more people should engage in physical activity every day of the week. Participating in physical activity is very safe for MOST people. This questionnaire will tell you whether it is necessary for you to seek further advice from your doctor OR a qualified exercise professional before becoming more physically active.

GENERAL HEALTH QUESTIONS

Please read the 7 questions below carefully and answer each one honestly: check YES or **NO**.	YES	NO
1) Has your doctor ever said that you have a heart condition ☐ **OR** high blood pressure ☐?	☐	☐
2) Do you feel pain in your chest at rest, during your daily activities of living, **OR** when you do physical activity?	☐	☐
3) Do you lose balance because of dizziness **OR** have you lost consciousness in the last 12 months? Please answer **NO** if your dizziness was associated with over-breathing (including during vigorous exercise).	☐	☐
4) Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)? **PLEASE LIST CONDITION(S) HERE:** _____	☐	☐
5) Are you currently taking prescribed medications for a chronic medical condition? **PLEASE LIST CONDITION(S) AND MEDICATIONS HERE:** _____	☐	☐
6) Do you currently have (or have had within the past 12 months) a bone, joint, or soft tissue (muscle, ligament, or tendon) problem that could be made worse by becoming more physically active? Please answer **NO** if you had a problem in the past, but it **does not limit your current ability** to be physically active. **PLEASE LIST CONDITION(S) HERE:** _____	☐	☐
7) Has your doctor ever said that you should only do medically supervised physical activity?	☐	☐

If you answered NO to all of the questions above, you are cleared for physical activity.
Please sign the PARTICIPANT DECLARATION. You do not need to complete Pages 2 and 3.

- Start becoming much more physically active – start slowly and build up gradually.
- Follow Global Physical Activity Guidelines for your age (https://apps.who.int/iris/handle/10665/44399).
- You may take part in a health and fitness appraisal.
- If you are over the age of 45 yr and NOT accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.
- If you have any further questions, contact a qualified exercise professional.

PARTICIPANT DECLARATION

If you are less than the legal age required for consent or require the assent of a care provider, your parent, guardian or care provider must also sign this form.

I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. I also acknowledge that the community/fitness center may retain a copy of this form for its records. In these instances, it will maintain the confidentiality of the same, complying with applicable law.

NAME _____ DATE _____

SIGNATURE _____ WITNESS _____

SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER _____

If you answered YES to one or more of the questions above, COMPLETE PAGES 2 AND 3.

Delay becoming more active if:

- You have a temporary illness such as a cold or fever; it is best to wait until you feel better.
- You are pregnant - talk to your health care practitioner, your physician, a qualified exercise professional, and/or complete the ePARmed-X+ at www.eparmedx.com before becoming more physically active.
- Your health changes - answer the questions on Pages 2 and 3 of this document and/or talk to your doctor or a qualified exercise professional before continuing with any physical activity program.

01-11-2019

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FOLLOW-UP QUESTIONS ABOUT YOUR MEDICAL CONDITION(S)

1. Do you have Arthritis, Osteoporosis, or Back Problems?

If the above condition(s) is/are present, answer questions 1a-1c — If **NO** ☐ go to question 2

1a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
1b.	Do you have joint problems causing pain, a recent fracture or fracture caused by osteoporosis or cancer, displaced vertebra (e.g., spondylolisthesis), and/or spondylolysis/pars defect (a crack in the bony ring on the back of the spinal column)?	YES ☐ NO ☐
1c.	Have you had steroid injections or taken steroid tablets regularly for more than 3 months?	YES ☐ NO ☐

2. Do you currently have Cancer of any kind?

If the above condition(s) is/are present, answer questions 2a-2b — If **NO** ☐ go to question 3

2a.	Does your cancer diagnosis include any of the following types: lung/bronchogenic, multiple myeloma (cancer of plasma cells), head, and/or neck?	YES ☐ NO ☐
2b.	Are you currently receiving cancer therapy (such as chemotheraphy or radiotherapy)?	YES ☐ NO ☐

3. Do you have a Heart or Cardiovascular Condition? This includes Coronary Artery Disease, Heart Failure, Diagnosed Abnormality of Heart Rhythm

If the above condition(s) is/are present, answer questions 3a-3d — If **NO** ☐ go to question 4

3a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
3b.	Do you have an irregular heart beat that requires medical management? (e.g., atrial fibrillation, premature ventricular contraction)	YES ☐ NO ☐
3c.	Do you have chronic heart failure?	YES ☐ NO ☐
3d.	Do you have diagnosed coronary artery (cardiovascular) disease and have not participated in regular physical activity in the last 2 months?	YES ☐ NO ☐

4. Do you currently have High Blood Pressure?

If the above condition(s) is/are present, answer questions 4a-4b — If **NO** ☐ go to question 5

4a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
4b.	Do you have a resting blood pressure equal to or greater than 160/90 mmHg with or without medication? (Answer **YES** if you do not know your resting blood pressure)	YES ☐ NO ☐

5. Do you have any Metabolic Conditions? This includes Type 1 Diabetes, Type 2 Diabetes, Pre-Diabetes

If the above condition(s) is/are present, answer questions 5a-5e — If **NO** ☐ go to question 6

5a.	Do you often have difficulty controlling your blood sugar levels with foods, medications, or other physician-prescribed therapies?	YES ☐ NO ☐
5b.	Do you often suffer from signs and symptoms of low blood sugar (hypoglycemia) following exercise and/or during activities of daily living? Signs of hypoglycemia may include shakiness, nervousness, unusual irritability, abnormal sweating, dizziness or light-headedness, mental confusion, difficulty speaking, weakness, or sleepiness.	YES ☐ NO ☐
5c.	Do you have any signs or symptoms of diabetes complications such as heart or vascular disease and/or complications affecting your eyes, kidneys, **OR** the sensation in your toes and feet?	YES ☐ NO ☐
5d.	Do you have other metabolic conditions (such as current pregnancy-related diabetes, chronic kidney disease, or liver problems)?	YES ☐ NO ☐
5e.	Are you planning to engage in what for you is unusually high (or vigorous) intensity exercise in the near future?	YES ☐ NO ☐

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6. Do you have any Mental Health Problems or Learning Difficulties? This includes Alzheimer's, Dementia, Depression, Anxiety Disorder, Eating Disorder, Psychotic Disorder, Intellectual Disability, Down Syndrome

If the above condition(s) is/are present, answer questions 6a-6b If **NO** ☐ go to question 7

6a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
6b.	Do you have Down Syndrome **AND** back problems affecting nerves or muscles?	YES ☐ NO ☐

7. Do you have a Respiratory Disease? This includes Chronic Obstructive Pulmonary Disease, Asthma, Pulmonary High Blood Pressure

If the above condition(s) is/are present, answer questions 7a-7d If **NO** ☐ go to question 8

7a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
7b.	Has your doctor ever said your blood oxygen level is low at rest or during exercise and/or that you require supplemental oxygen therapy?	YES ☐ NO ☐
7c.	If asthmatic, do you currently have symptoms of chest tightness, wheezing, laboured breathing, consistent cough (more than 2 days/week), or have you used your rescue medication more than twice in the last week?	YES ☐ NO ☐
7d.	Has your doctor ever said you have high blood pressure in the blood vessels of your lungs?	YES ☐ NO ☐

8. Do you have a Spinal Cord Injury? This includes Tetraplegia and Paraplegia

If the above condition(s) is/are present, answer questions 8a-8c If **NO** ☐ go to question 9

8a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
8b.	Do you commonly exhibit low resting blood pressure significant enough to cause dizziness, light-headedness, and/or fainting?	YES ☐ NO ☐
8c.	Has your physician indicated that you exhibit sudden bouts of high blood pressure (known as Autonomic Dysreflexia)?	YES ☐ NO ☐

9. Have you had a Stroke? This includes Transient Ischemic Attack (TIA) or Cerebrovascular Event

If the above condition(s) is/are present, answer questions 9a-9c If **NO** ☐ go to question 10

9a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
9b.	Do you have any impairment in walking or mobility?	YES ☐ NO ☐
9c.	Have you experienced a stroke or impairment in nerves or muscles in the past 6 months?	YES ☐ NO ☐

10. Do you have any other medical condition not listed above or do you have two or more medical conditions?

If you have other medical conditions, answer questions 10a-10c If **NO** ☐ read the Page 4 recommendations

10a.	Have you experienced a blackout, fainted, or lost consciousness as a result of a head injury within the last 12 months **OR** have you had a diagnosed concussion within the last 12 months?	YES ☐ NO ☐
10b.	Do you have a medical condition that is not listed (such as epilepsy, neurological conditions, kidney problems)?	YES ☐ NO ☐
10c.	Do you currently live with two or more medical conditions?	YES ☐ NO ☐

PLEASE LIST YOUR MEDICAL CONDITION(S) AND ANY RELATED MEDICATIONS HERE: _____

_____

GO to Page 4 for recommendations about your current medical condition(s) and sign the PARTICIPANT DECLARATION.

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If you answered NO to all of the FOLLOW-UP questions (pgs. 2-3) about your medical condition, you are ready to become more physically active - sign the PARTICIPANT DECLARATION below:

- It is advised that you consult a qualified exercise professional to help you develop a safe and effective physical activity plan to meet your health needs.
- You are encouraged to start slowly and build up gradually - 20 to 60 minutes of low to moderate intensity exercise, 3-5 days per week including aerobic and muscle strengthening exercises.
- As you progress, you should aim to accumulate 150 minutes or more of moderate intensity physical activity per week.
- If you are over the age of 45 yr and **NOT** accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.

If you answered **YES** to **one or more of the follow-up questions** about your medical condition:

You should seek further information before becoming more physically active or engaging in a fitness appraisal. You should complete the specially designed online screening and exercise recommendations program - the **ePARmed-X+ at www.eparmedx.com** and/or visit a qualified exercise professional to work through the ePARmed-X+ and for further information.

Delay becoming more active if:

- You have a temporary illness such as a cold or fever; it is best to wait until you feel better.
- You are pregnant - talk to your health care practitioner, your physician, a qualified exercise professional, and/or complete the ePARmed-X+ **at www.eparmedx.com** before becoming more physically active.
- Your health changes - talk to your doctor or qualified exercise professional before continuing with any physical activity program.

- You are encouraged to photocopy the PAR-Q+. You must use the entire questionnaire and NO changes are permitted.
- The authors, the PAR-Q+ Collaboration, partner organizations, and their agents assume no liability for persons who undertake physical activity and/or make use of the PAR-Q+ or ePARmed-X+. If in doubt after completing the questionnaire, consult your doctor prior to physical activity.

PARTICIPANT DECLARATION

- All persons who have completed the PAR-Q+ please read and sign the declaration below.
- If you are less than the legal age required for consent or require the assent of a care provider, your parent, guardian or care provider must also sign this form.

I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. I also acknowledge that the community/fitness center may retain a copy of this form for records. In these instances, it will maintain the confidentiality of the same, complying with applicable law.

NAME _____ DATE _____

SIGNATURE _____ WITNESS _____

SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER _____

For more information, please contact
www.eparmedx.com
Email: eparmedx@gmail.com

Citation for PAR-Q+
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Key References

1. Jamnik VK, Warburton DER, Makarski J, McKenzie DC, Shephard RJ, Stone J, and Gledhill N. Enhancing the effectiveness of clearance for physical activity participation; background and overall process. APNM 36(S1):S3-S13, 2011.
2. Warburton DER, Gledhill N, Jamnik VK, Bredin SSD, McKenzie DC, Stone J, Charlesworth S, and Shephard RJ. Evidence-based risk assessment and recommendations for physical activity clearance; Consensus Document. APNM 36(S1):S266-s298, 2011.
3. Chisholm DM, Collis ML, Kulak LL, Davenport W, and Gruber N. Physical activity readiness. British Columbia Medical Journal. 1975;17:375-378.
4. Thomas S, Reading J, and Shephard RJ. Revision of the Physical Activity Readiness Questionnaire (PAR-Q). Canadian Journal of Sport Science 1992;17:4 338-345.

11-01-2019