Dear Prospective Faculty & Staff Fitness Program Member:

We are pleased that you are interested in the Faculty & Staff Fitness Program. The program is designed to help you safely begin a regular exercise program and stick with it.

Who is eligible?

All OSU faculty, staff, retirees, and their spouses or domestic partners are eligible for membership.

To become a member:

1. Complete and email pages 4-8 of this document to **EHE-FSFP@osu.edu**.

2. Take pages 9-10 of this document to your physician and have them either email it to **EHE-FSFP@osu.edu** or fax to 614-688-3432.

3. Once all forms have been received, Maggie Roe will email you with a link to schedule a fitness evaluation. This fitness evaluation includes a body composition assessment, cardiorespiratory fitness test, muscular strength measures, and flexibility measurements. You are eligible for an evaluation every year.

4. Please read the pre-test instructions sent by Maggie before your scheduled fitness evaluation. These can also be found on our website: **http://fsfp.ehe.osu.edu**

5. The fitness evaluation results, and exercise program recommendations will be explained by your session leader during your follow up appointment.

Days/times listed below for fitness evaluations are those expected, however scheduling requirements or facility availability occasionally require time changes.

Monday-Friday 6:00am-8:00am and 4:30pm-6:30pm

Membership Fees and Payment

Two payment plans are available for those wishing to join:

If paying yearly

Includes initial fitness evaluation and 12 months of membership	$200.00
Payroll deduction **(NO refunds for early cancellation)**	$16.67/month

If paying 3 months at a time

Includes initial fitness evaluation and 3 months of membership	$120.00
Each subsequent 3 months of membership	$90.00
Payroll deduction	**Not Available**

Payroll deduction is only available to current faculty and staff. Retirees, spouses, and domestic partners can bring a check, money order, or cashier check made payable to OSU. Please bring Payroll Deduction Form (see next page) or payment on the day of your scheduled fitness evaluation. If you have any further questions, please feel free to email or call Maggie. We look forward to your participation in the program soon.

Welcome and happy exercising!

Maggie Roe
Faculty and Staff Fitness Program Manager
Department of Human Sciences - Kinesiology
The Ohio State University
A042 PAES Building
305 Annie and John Glenn Avenue
Columbus, OH 43210-1224

Phone: 614-247-0287
Email: EHE-FSFP@osu.edu

WMS Legal

FSFP Payroll Deduction

The Ohio State University Faculty and Staff Fitness Program (OSU FSFP)
A042 PAES Building
305 Annie and John Glenn Ave
Columbus, OH 43210
Phone: 614-247-0287

Participant Name_____OSU ID#_____

Street Address_____

City, State, Zip_____Phone (___)_____

Email Address _____

_____**One-Year Fitness Membership ($200) - Monthly**

12 Monthly payments of $16.67 will be automatically deducted from my Ohio State University paycheck
(effective 2/1/2018: 12-month commitment required. No refunds will be given for early cancellations)

Effective immediately, I hereby authorize The Ohio State University to deduct the membership fees indicated above from my Ohio State University paycheck on an after-tax basis. I understand and agree that, if a deduction is missed for any reason, I am still financially responsible for the membership fees. ***I understand I am agreeing to a 12-month commitment, which may not be terminated early. If I choose to end my membership early, I am still responsible for the remaining amount owed.*** I have received a copy of the OSU FSFP policies and procedures regarding my use of the facility and agree to the terms outlined in those policies and procedures.

Signed_____**Date**_____

Office Use Only

Member ID#_____ Payroll Deduction _____to _____

Payment date: _____ Service dates _____to_____

Prepared by: _____ KI_____

12/10/2024
{00273245-1}

THE OHIO STATE UNIVERSITY

Faculty & Staff Fitness Program

In order to determine my personal fitness, I the undersigned, voluntarily request the right to participate in the Faculty & Staff Fitness Program being offered by the Department of Human Sciences of The Ohio State University, commencing _____ (month), 20_____(year).

As part of said program, I understand and agree to the following:

1. An evaluation will be conducted to determine my body composition, cardiorespiratory fitness, strength, and flexibility. Complications during exercise tests have been few. If the individual exercising is not tolerating it well, this usually becomes apparent, and the exercise is stopped. Mild light-headedness and even fainting may occur. However, they are uncommon and disappear quickly after lying down. Other risks of injury while using equipment involved in testing are possible, but rare.
2. The most demanding test will be the cardiorespiratory evaluation, which typically consists of walking or running on a treadmill to examine my heart rate response to graded exercise.
3. The results of said tests are not to be construed as diagnostic in any sense, but rather are to be used only to establish an exercise program with certain guidelines. This program will be designed to improve my physical fitness.
4. The results of such evaluation do not constitute a clearance of any kind but are only to be considered in connection with said program.
5. My private physician and/or consultant physicians involved in the program are hereby authorized to discuss with those responsible for the exercise program any aspect of my medical history and/or examination which may be appropriate or necessary for my evaluation for or participation in the Faculty & Staff Fitness Program.
6. I will need to request written authorization from my personal physician before being allowed to participate in this program.
7. The Faculty & Staff Fitness Program is not a substitute in any way for a physical examination by my physician, and I agree to consult my physician for such examination and for such medical care as I require.
8. This program, and any tests and exercises, which are a part of it are all offered on a voluntary basis. I am not obligated to participate and may withdraw at any time.
9. It is possible for injury to occur through this program, and I agree to fully assume that risk.
10. I have carefully read and understand the above information. The program, tests, and exercises have also been explained to me, and any questions have been answered to my satisfaction. I wish to participate in the Faculty & Staff Fitness Program.

Signature: _____ Date: _____

(Revised 6/16)

RELEASE OF ALL CLAIMS

Faculty & Staff Fitness Program

The Ohio State University (the "University") in support of the educational activities within its Department of Human Sciences (the "Department") is offering a Faculty & Staff Fitness Program, commencing

_____(month), 20_____ (year).

Although I realize that it is possible for injury to occur through this testing and/or exercise program, I agree to the following:

In consideration of being granted the opportunity to participate in the "Faculty & Staff Fitness Program", and to use equipment and receive the help, assistance, and advisory services rendered by members of the staff and employees of the University during this program, I release and forever discharge for myself and my heirs, executors, administrators, and assigns, The Ohio State University and its officers, agents, and employees who arrange, provide, advise, or supervise the above program, and/or any testing and exercise activities there under or any other function associated with participation in this program, from all claims, demands, actions, and causes of action for personal injury or any other damages now existing or which may hereafter arise out of or be in any way related to their conduct associated with the activities of the Department.

Signature: _____ Date: _____

(Revised 6/16)

THE OHIO STATE UNIVERSITY
COLLEGE OF
EDUCATION AND HUMAN ECOLOGY

Medical History Form

Date: _____ Date of Birth:_____Height:_____ Weight:_____

Name: _____ Address: _____

City: _____ State: _____ Zip:_____ Phone: _____

BuckID (if applicable): _____ Email:_____

Emergency Contact	Relationship to Client	Emergency Contact Phone

Do you have, or have you ever had, any of the following High-Risk Events? (Please mark Yes or No)

	Yes	No
Heart Attack		
Any Heart Disease/Condition		
Any Heart-related Surgery		
Chest Discomfort/Palpitations		
Dizziness/Unconsciousness		
Shortness of Breath		
Uncontrolled Blood Pressure		

Please answer the following if you have marked yes to any of the High-Risk Events:

Procedures: _____Date: _____

Physician : _____ Last Visit: _____

Do you have any of these Moderate-Risk Conditions? (Please mark Yes or No)

	Yes	No		Yes	No
High Blood Pressure—controlled or treated			Blood relative heart attack/surgery before 55?		
High Cholesterol			Any surgeries in the past 6 months?		
Diabetes or Pre-Diabetes			Any pain rated higher than 6/10? (10 is worse)		
Asthma/Lung Disease?			Physician has given activity restrictions?		
Do you currently smoke?			Have you ever been a smoker in the past?		

Have you ever had any of the following? (Please mark Yes or No)

	Yes	No		Yes	No
Cancer			Allergies		
Seizures			Fibromyalgia		
Mental Health Problems			Concussion/Unconsciousness		
Anemia			Hernia		
Thyroid Disorder			Osteopenia/Osteoporosis		
Currently Pregnant			Vertigo		

Please List any Medications, Vitamins, or Supplements you are currently taking:

Drug/Vitamin Name	Dosage	Reason for Taking

Have you ever had any of the following? (Please mark Yes or No)

Head/Neck	Yes	No
Pinched Nerve		
Frequent Headaches		
Migraines		
Fracture		
Sprain/Strain		
Arthritis		
Disc Problems		
Surgery:_____		
Other:_____		
Shoulder	**Yes**	**No**
Fracture		
Dislocation		
Sprain/Strain		
Arthritis		
Rotator Cuff		
Frozen Shoulder		
Shoulder Impingement		
Surgery: _____		
Other: _____		

Arm/Hand	Yes	No
Fracture		
Sprain		
Arthritis		
Surgery:_____		
Other:_____		
Chest/Abdominal	**Yes**	**No**
Fractured Rib		
Hernia		
C-Section		
Other:_____		
Back	**Yes**	**No**
Fracture		
Arthritis		
Bulge/Herniated Disc		
Pinched Nerve		
Surgery: _____		
Other: _____		

Hip	Yes	No
Fracture		
Dislocation		
Tendonitis		
Arthritis		
Replacement		
Surgery:_____		
Other:_____		
Upper Leg (Quad/HS)	**Yes**	**No**
Sprain/Strain		
Surgery:_____		
Other:_____		
Lower Leg (knee/ankle/ foot)	**Yes**	**No**
Fracture		
Arthritis		
Ligament Damage		
Sprain/Strain		
Plantar Fasciitis		
Surgery:_____		
Other:_____		

Fitness and Wellness Needs Assessment

Are you interested in the following services? (Please mark Yes or No)

	Yes	No
Advanced Body Composition and Exercise Testing		
Low-Carbohydrate Nutrition Coaching		
Exercise Prescription and Personal Training by Student Intern (with Program Manager supervision)		

Please answer the following questions:

What is your exercise experience? (mark one)

Beginner ☐ *Intermediate* ☐ *Advanced* ☐

What strength training activities interest you? (mark all that apply)

Weight Machines ☐ *Dumbbells* ☐ *Cable Exercises* ☐ *Band Exercises* ☐ *Plate Loaded Equipment* ☐ *Body Weight/TRX* ☐

What cardiovascular activities interest you? (mark all that apply)

Walking ☐ *Elliptical* ☐ *Bikes* ☐ *Swimming/Water Aerobics* ☐ *Running* ☐ *Group Exercise Classes* ☐

What type of exercise program are you interested in developing? (please mark one)

All Strength Training ☐ *Strength and Cardiovascular mix* ☐ *All Cardiovascular Activity* ☐

Current Health Status (Please mark Yes or No)	**Yes**	**No**
Are you exercising a minimum of 3 times per week for at least 30 min at a time? If yes, please specify the type of exercise:_____	☐	☐
Do you feel your current or previous exercise routines are/were successful?	☐	☐
Do you feel your stress level you experience daily is higher than it should be?	☐	☐

Fitness Expectations/Goals:

1. _____
2. _____
3. _____

How many days per week do you anticipate exercising at our facility? (mark one)

1-2 days ☐ 3-4 days ☐ 5 days ☐

How long do you anticipate exercising at our facility? (mark one)

15-30 minutes ☐ 31-45 minutes ☐ 46-60 minutes ☐ Longer than 60 minutes ☐

Present this letter to your physician with the following medical clearance form and have them fax or email it back to us.

Dear Dr. _____,

Your patient, _____, has applied for membership to the Faculty & Staff Fitness Program, Department of Human Sciences/Kinesiology at The Ohio State University.

This program involves a symptom limited graded cardiorespiratory fitness test for the evaluation of each participant's initial fitness level. This test, performed on a treadmill, is administered by staff and students in exercise physiology. Also, included is a measurement of upper and lower body strength, and body composition. The participant's exercise recommendations, based on these results, may include but are not limited to any combination of the following: walking, jogging, swimming, or strength training of specific muscle groups. The program sessions are always supervised.

By completing the enclosed medical clearance form, we acknowledge that you are not assuming any responsibility for our administration of this program. However, if you know of any medical or other reasons why participation in this fitness program would not be in the best interest of this individual, we would appreciate your indication on the enclosed Report of the Personal Physician form. Thank you for your help.

Sincerely,

Maggie Roe
Faculty and Staff Fitness Program Manager
Department of Human Sciences - Kinesiology
The Ohio State University
A042 PAES Building
305 Annie and John Glenn Avenue
Columbus, OH 43210-1224

Phone: 614-247-0287
Fax: 614-688-3432
Email: EHE-FSFP@osu.edu

Enclosure

The Ohio State University
Faculty & Staff Fitness Program
Physician's Medical Clearance Form

REPORT OF PERSONAL PHYSICIAN

Patient Name: _____

Please check the most appropriate box:

☐ 1. I know of no reason why they may not participate.

☐ 2. I believe they could participate, but urge caution because of:

_____

_____

☐ 3. I recommend they not participate due to:

_____

_____

Physician's Signature: _____

Physician's Name (Print): _____

Physician's Address: _____

_____

Physician's Fax number: _____

The below signature is required of all individuals wishing to join FSFP.
I hereby authorize the release of my fitness evaluation results to the physician named above.

Patient Signature: _____ Date: _____

(Revised 12/24)