



Medical Release and Member Application 2017

Membership in TEAMSURVIVOR Madison, Inc. is open to women with any cancer diagnosis.

Name _____ Preferred Name _____ Birthdate: Mo. ___ Day ___ Yr. ___

I am a new member _____ I am renewing my membership _____ Year joined _____

I was diagnosed with _____ in _____ (year)

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Cell phone: _____ Email: _____

Membership is \$25 annually, which helps cover organizational operating expenses and offer you variety in programming.

TEAMSURVIVOR Madison, Inc.(TSM) will contact you via email unless otherwise specified.

I give permission to share my contact info. (name, address, phone, etc) with TSM, members in the TSM Directory.

I do not want my contact information to be included in the membership directory (given only to TSM Members).

How did you learn about TEAMSURVIVOR Madison, Inc.? _____

To help us plan TEAMSURVIVOR Madison, Inc. programs, please complete the interest inventory below. CIRCLE any activities you are interested in participating in with TSM. You can be new to the activity or have experience.

Activity	Activity	
INDOOR CLASSES : Pilates / Yoga / Tai Chi Fitness, Conditioning, Weights Water Aerobics	OUTDOOR WATER SPORTS: Dragonboating Canoe / Kayak Stand-up Paddling	If you have expertise and willingness to lead an activity, please indicate the activity here.
OUTDOOR SPORTS: Walking / Running / Hiking, Biking Golf	WINTER SPORTS: Snow Shoeing Cross Country Skiing	
TRIATHLON TRAINING Swim / Bike / Run/Walk	OTHER: List here	If you have organizational, communications, accounting, etc. skills to offer TSM, please indicate your interest here.

Do you currently belong to a health club? No Yes _____ (list health club name)

MEDIA RELEASE (optional)

The undersigned, or their designee, agrees to allow TEAMSURVIVOR Madison, Inc. to identify me as a member of the organization, use my demographic information and name, voice and/or likeness in public communications including but not limited to: printed materials, membership directory, Web site and advertising.

MEMBER SIGNATURE _____ Date _____

Dear _____ (PHYSICIAN NAME):

I, _____ (patient name), wish to participate in the following physical activities and/or training programs offered by TEAMSURVIVOR Madison, Inc. **(to be completed by patient):** _____

Please list any restrictions that you would recommend for this program **(to be completed by physician):**

Physical limitations: _____

Other restrictions: _____

_____ (patient name) has my approval to participate in this physical activity with the restrictions described above.

PHYSICIAN'S SIGNATURE: _____ Date _____, 2016

Completion of the "Medical Release and Member Application" form is required annually for membership in TEAMSURVIVOR Madison, Inc. **Incomplete forms will be returned for completion.** Please enclose \$25 or send separately. NO MEMBER will be turned away due to financial hardship. Let us know if you need special consideration.

Please return completed form to: TEAMSURVIVOR Madison, Inc., P.O. Box 46603, Madison, WI 53744-6603

Questions?: Email info@teamsurvivormadison.org

www.teamsurvivormadison.org

12-16-16

Office use only : _____ Member fee paid _____ Date _____