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 programing.

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		If you have organizational, communications, accounting, etc. skills to offer TSM, please indicate your interest here.
TRIATHLON TRAINING Swim / Bike / Run/Walk		OTHER: List 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):

Provider Network:____

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

____

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

____.

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

Physician SIGNATURE: ____ Date____________________, 2017

**TSM member is responsible for following any activity restrictions noted by their provider.*

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 01-30-17

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Office use only : ________Member fee paid ______________Date