

# Wellness Center Member Application

**Please note: You must fill out this application completely or it will be returned to you.**

## Check the category of your present status

Employee       Employee spouse       Retiree       Retiree spouse

## Check the name of the location you are applying for

Bangor Wellness Center       Eastside Wellness Center

State of Maine Insurance Card # \_\_\_\_\_ Social Security # \_\_\_\_\_

\_\_\_\_\_  
Name (please print)      Home Phone      Work Phone

\_\_\_\_\_  
Home Address      City      State      Zip      Age      DOB

\_\_\_\_\_  
Department      Department Number      Department Location  
**(can be found on paystub)**

\_\_\_\_\_  
Department Address      Department City

\_\_\_\_\_  
Email      Emergency Contact Name      Emergency Contact Phone

\_\_\_\_\_  
Physician      Phone      Fax

## HEALTH HISTORY (Please check the applicable box)

- Yes  No Do you lose your balance because of dizziness or do you ever lose consciousness?
- Yes  No Has your doctor ever said you have a heart condition and should only do physical activity recommended by a doctor?
- Yes  No Do you feel pain in your chest when you do physical activity?
- Yes  No Are you being treated for high blood pressure? If yes, please indicate what method of treatment/medications you use. \_\_\_\_\_
- Yes  No Do you have diabetes?
- Yes  No Do you have asthma or any other respiratory problems?
- Yes  No Do you have a bone or joint problem that could be made worse by a change in your physical activity?
- Yes  No Are you participating in physical and/or occupational therapy?  
If yes, where: \_\_\_\_\_

Turn over please

Yes  No Are you pregnant?

Yes  No If no, have you given birth in the last six months?

How did you hear about the Wellness Center?

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I have read and am responsible for following the Wellness Center Code of Conduct.

*I certify the above information is true. I agree to notify MaineGeneral staff of any changes to this information and/or my medical status.*

Signature \_\_\_\_\_ Date \_\_\_\_\_

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**OFFICE USE ONLY:**

Member ID # \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_

Yes  No Have we received a copy of the insurance card? Initials: \_\_\_\_\_

Yes  No Did Active Employee or Spouse show state ID badge? Initials: \_\_\_\_\_

Yes  No Did New Retiree or Spouse show insurance card? Initials: \_\_\_\_\_

Yes  No Did Spouse say he/she is not covered by insurance? Initials: \_\_\_\_\_

