EQUIPD COMMUNITY GYM SUBSIDY APPLICATION

EQUIPD
ALLIED HEALTH

PERSONAL INFORMATION

Full Name	
Date Of Birth	
Concession Card Type	□ Health Care Card □ Pensioner Concession Card □ Seniors Card □ Other: _____
Phone Number:	
Email Address:	

SERVICE ENGAGEMENT

Do you currently engage in any of the following services (select all that apply)?

□ Exercise Physiology
□ Physiotherapy
□ Personal Training
□ Podiatry
□ Occupational Therapy
□ Speech Pathology
□ Remedial Massage
□ Chiropractic Treatment
□ Chinese Medicine
□ Other: _____

Do you currently hold a membership at a recreation facility, health club, gym, or similar?
□ Yes (Please specify): _____
□ No

GYM EXPERIENCE & EXERCISE PROGRAM

Do you have experience in a gym setting?
□ Yes (Please provide details): _____
□ No

Do you require assistance in understanding how to use cardiovascular and pin-loaded exercise equipment?
□ Yes
□ No

Do you have a prescribed exercise program that you can complete in the EQUIPD community gym?
□ Yes
□ No

PRE-EXERCISE SCREENING QUESTIONNAIRE

1. Has your medical practitioner ever told you that you have a heart condition or have you ever suffered a stroke? ☐ Yes ☐ No

2. Do you ever experience unexplained pains or discomfort in your chest at rest or during physical activity/exercise? ☐ Yes ☐ No

3. Do you ever feel faint, dizzy or lose balance during physical activity/exercise? ☐ Yes ☐ No

4. Have you had an asthma attack requiring immediate medical attention at any time over the last 12 months? ☐ Yes ☐ No

5. If you have diabetes (type 1 or 2) have you had trouble controlling your blood sugar (glucose) in the last 3 months? ☐ Yes ☐ No

6. Do you have any other conditions that may require special consideration for you to exercise? (Please provide details): _____ ☐ Yes ☐ No

MEDICAL PRACTITIONER ENGAGEMENT

Depending on your answers above, you may require support from EQUIPD's Exercise Physiologist, including an initial consultation, to assist with your transition into the gym environment.

Are you prepared to engage with your medical practitioner regarding a referral to an Exercise Physiologist:
☐ Yes ☐ No

Note: Medicare benefits are available for services provided by Exercise Physiologists to patients with chronic or terminal conditions and complex care needs managed by a GP using Chronic Disease Management (CDM) MBS items.

EQUIPD will bulk bill eligible sessions as part of this gym subsidy transition.

SUBSIDY REQUEST

How much are you hoping EQUIPD can subsidise your membership? (Up to the maximum $22/week full-price membership)

Amount: $_____

How many times do you wish to utilise the gym weekly?
☐ 1-2 times ☐ 3-4 times ☐ 5+ times

How many group exercise classes do you wish to attend weekly?
☐ 1 class ☐ 2 classes ☐ 3+ classes

Are you willing to submit a subsidy renewal application every six months?
☐ Yes ☐ No

SIGNATURE

I declare that the information provided in this application is true and correct to the best of my knowledge.

Signature: _____ Date: _____