CITY OF IDAHO FALLS
EMPLOYEE FITNESS & RECREATIONAL BENEFITS PROGRAM
MEMBERSHIP APPLICATION

EMPLOYEE INFORMATION		
Name:		
Date of Birth:		
Work Phone:	Cell Phone:	
Email:		
Current Address:		
City:	State:	ZIP Code:
Department of Employment:		
Position:	How long?	
EMERGENCY CONTACT		
Name:		
Address:	Phone:	
City:	State:	ZIP Code:
Relationship to Employee:		

AUTHORIZATION FOR MEDICAL TREATMENT/INDEMNIFICATION

I hereby authorize and give my consent to the City of Idaho Falls and its officers, agents and employees and any licensed physician to perform upon or administer any reasonable and necessary medical, surgical or emergency treatment as necessary in their best judgment to stabilize my condition or to preserve life or limb. I further agree to pay for all necessary medical treatment as so authorized and to hold harmless and release the City and its' officers or agents from any obligation or responsibility with respect thereto. I further represent that I have no condition, illness, disease, disability or other limitation that would pose any potential risk of bodily harm or injury to me, except as disclosed above. I further represent that I have no allergy to any medication or other condition limiting the administration of drugs or medication, except as otherwise disclosed above.

I further agree to indemnify and hold harmless any officer, agent or employee of the City from any and all actions, causes of actions, suits, injury claims, or demands asserted by any third party, with respect to any act, omission, wrongful or unlawful conduct by me during the course of my participation in program/activity.

This Agreement shall be binding upon the heirs, personal representatives, successors, and assigns of the undersigned.

Signature of Employee:	**Date:**

HR OFFICE USE ONLY

☐ **Regular/PERSI**

☐ **Seasonal**

Initial of Official HR Representative: ☐

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