TRI-CITY PHYSICAL THERAPY

2805 WHIPPLE ROAD
UNION CITY, CALIFORNIA 94587
TEL. (510) 441-8906 ✦ FAX (510) 441-8908
www.tricitypt.com

3870 MOWRY AVENUE
FREMONT, CALIFORNIA 94538
TEL. (510) 790-9480 ✦ FAX (510) 790-9490
Kokila@tricitypt.com

CIRCUIT TRAINING ENROLLMENT FORM

_____ _____ _____
Last Name First Name Date

_____ _____ ____ _____
Street Address City State Zip Code

_____ _____ _____
Home Phone Work Phone Email Address

Age: _____ Occupation:_____

Have you attended Circuit Training before? (Yes/No) _____

Do you have any medical conditions that might prohibit you from doing circuit training? (Yes/No) ____

If yes, please explain: _____

_____

What do you expect from this class? _____

_____

How did you hear about this class? _____

_____

Your primary physician: _____ Phone: _____

Name of Parent/ Guardian to be contacted in case of an emergency:

_____ _____ _____
Name Phone Work phone

I understand that by enrolling in this circuit training program, it is assumed that I am in reasonably good physical health. Although the circuit trainer will monitor the abilities of the class as a whole and set the pace of the class accordingly, I know that I am ultimately responsible for participating only to the extent to which I am able and assume any risks involved.

Signature: _____ ***Date:***_____