RehabFit

PLEASE CALL 238-2225 TO SCHEDULE AN APPOINTMENT

MEMBERSHIP AGREEMENT

1. CLIENT INFORMATION					
FIRST NAME		LAST NAME		BIRTH DATE	
ADDRESS		CITY		POSTAL CODE	
MOBILE		HOME TEL.		WORK TEL.	
EMAIL				GENDER	
EMERGENCY CONTACT		EMERGENCY TEL.			
PCP					

2. PAYMENT OF OBLIGATION AND RENEWAL DUES

I hereby authorize and request Speare Memorial Hospital doing business as RehabFIT (hereinafter referred to as RehabFIT) to initiate withdrawal entries to my account indicated below and the financial institution named below, hereinafter called Bank, to withdraw the same from such account.

PAYMENT METHOD		CREDIT CARD #		EXPIRY	

3. TERMS AND CONDITIONS (see next page for assumption of risk, release and waiver of liability, and full terms and conditions)

- **Do not sign this contract until you have read the entire agreement.**
- **Do not sign this contract if it contains any blank spaces.**
- **State law requires that this health club register with the bureau of consumer protection and antitrust of the department of justice and may require that this facility post a bond to protect customers who pay in advance for membership or services in the event this facility closes. You should ask to see evidence that this club has either posted a bond in compliance with the law or has been exempted from this requirement by the attorney general before you sign this contract. If this club has not posted such a bond, and you pay this health club for more than one (1) months membership or services in advance, then you are paying for future services, and you may be risking the loss of your money in the event that the facility ceases to conduct business.**
- **YOU MAY CANCEL THIS TRANSACTION IN WRITING ANY TIME PRIOR TO MIDNIGHT OF THE THIRD BUSINESS DAY AFTER THE DATE OF THIS TRANSACTION.**

My signature also hereby consents RehabFIT shall have the right to publish any photo(s) taken of me. These photo(s) will be used in connection to the RehabFIT advertising by the newspaper, social media, and newsletter.

RehabFit

Medical Fitness Center

ASSUMPTION OF RISK

I, the undersigned, hereby expressly and affirmatively state that I fully understand that physical activity, by its very nature carries with it certain inherent risks that cannot be eliminated regardless of the care to avoid injuries. RehabFIT has facilities for and provides activities such as weight training, cardiovascular training and other aerobic activities and more. Some of these activities involve strenuous exertions of strength using various muscle groups, some involve quick movements, involving speed and change of direction and others involve sustained physical activity, which places stress on the cardiovascular system. The specific risks vary from one activity to another, but in each activity the risks range from minor to catastrophic including paralysis and death.

- **I understand the nature of the activities and services offered by RehabFIT.**
- **I understand the demands of those activities relative to my physical condition and skill level.**
- **I appreciate the types of injuries, which may occur as a result of my participation in the activities and services offered by RehabFIT.**
- **I am physically able to participate and my participation in any such activity or service is voluntary and I knowingly assume all associated risks in doing so.**
- **I have read this document and fully understand its contents.** I acknowledge that I am signing this freely and voluntarily and intend my signature to attest to **my complete assumption of any and all risks of my participation in any of the activities or services offered by RehabFIT.**

RELEASE AND WAIVER OF LIABILITY

In consideration of gaining membership and/or permission to participate in the activities, programs and/or services of SPEARE MEMORIAL HOSPITAL, doing business as RehabFIT and to use its facilities, premises, equipment and machinery, I, on behalf of myself, my heirs, personal representatives, or assigns do hereby release, waive, forever discharge and covenant not to sue and agree to release, discharge, hold harmless and indemnify SPEARE MEMORIAL HOSPITAL, doing business as RehabFIT and all of each entities' directors, officers, employees, volunteers, independent contractors, agents and all other affiliated persons or entities (herein collectively referred to as RehabFIT) from and against any and all responsibilities or liabilities for injuries or damages to my person or property resulting from my use of the facilities or premises or otherwise from my participating in any activities offered by RehabFIT or my use of equipment machinery made available by RehabFIT or engaging in any other service offered by RehabFIT. I do also hereby release RehabFIT and any others acting upon its behalf from any responsibility or liability for any injury (including death) to myself, including any injury caused by negligent act or omission of RehabFIT or others acting on its behalf or in any way arising out of or connected to my participation in any of the aforementioned activities or the use of any equipment, machinery or other facilities or premises at RehabFIT. This agreement applies to all liability for personal injury (including death) from accidents or illnesses arising from RehabFIT's failure to maintain or supervise said facility or premises, as well as my participation in such activities described throughout this agreement including, but not limited to, organized activities, classes, observation, as well as any individual use of facilities, premises, equipment or machinery, as well as from:

- Receiving instruction, guidance or testing from exercise professionals, trainers or instructors
- Participation in group exercise classes
- Participation in strength training
- Use of cardiovascular equipment
- Use of free weight equipment
- Use of any Community Room
- Use of any lock and shower facilities
- Use of any other equipment/activities/services that may be added over time.

RehabFit

Medical Fitness Center

TERMS AND CONDITIONS

MEMBERSHIP RULES AND REGULATIONS

1. Members may use the facilities of RehabFIT during any operating hours.
2. Members are required to sign each time they enter the facility.
3. Members may not allow other persons to use their membership card.
4. Members must abide by all membership and facility rules and regulations that may be prominently posted from time to time.
5. Members must be at least eighteen (18) years old. Minors who have attained the age of ten (10) may become Members provided a parent/guardian also signs this contract and assumes and guarantees all obligations of the minor Member.

MEMBERS RIGHTS

(a) Refund to the member the pro rata cost of any unused services within fifteen (15) days after request therefor, if:
(1) The member is unable to receive benefits from RehabFIT's services by reason of death or disability. RehabFIT may require that the disability be confirmed by an examination of a physician agreeable to the member and the health club; provided however, that this subparagraph shall not operate to prevent the member from providing the disability in a judicial proceeding; or
(2) RehabFIT relocates its facility more than eight (8) miles from its present location, or the services provided by RehabFIT are materially impaired.
(b) Refund to the member the pro rata cost of any unused services under all contracts between the parties, within fifteen (15) days after request therefor, if the aggregate price of all contracts in force between the parties exceeds $1,000.00. Provided, however, if the contract so provides, RehabFIT may retain a cancellation fee of not more than 25 percent of the pro rata cost of unused services on all contracts, not to exceed $250.00.
(c) Refund to the member the pro rata cost of any unused services within fifteen (15) days after the club ceases operation.

Upon the occurrence of any of the circumstances in subparagraphs (a) or (b) or (c) of this section, the member or his estate shall be relieved of any further obligations for payment under the contract not then due and owing.

AUTHORIZATION AGREEMENT FOR PREAUTHORIZED PAYMENTS

I hereby authorize and request Speare Memorial Hospital doing business as RehabFIT (hereinafter referred to as RehabFIT) to initiate withdrawal entries to my account indicated below and the financial institution named below, hereinafter called Bank, to withdraw the same from such account.

This authority is to remain in full force and effect until RehabFIT and Bank receive written notification from me of its termination at such time and in such manner as to afford RehabFIT and Bank a reasonable opportunity to act on it. By taking such action, this does not relieve me from contractual obligations to RehabFIT.

CONTRACT TERM

This document represents a month to month membership contract to the fitness center known as RehabFIT located at Boulder Point, the Health Place, 103 Boulder Point Road, Plymouth, NH, 03264. RehabFIT is a department of Speare Memorial Hospital and is engaged in the operation of a fitness center and offers for sale membership to use the facilities and/or services offered.

It is understood and agreed that this membership shall continue month to month upon completion of the original specified month term. Members shall make all payments to RehabFIT at the address shown above unless RehabFIT notifies the Member in writing to make payments to a different address. The monthly fee can be increased provided RehabFIT posts written notice of the increase in a prominent location and provides Members with, at least, sixty (60) days written notice of the increase.

FREEZING A MEMBERSHIP

1. A member may freeze their membership at any time for an indefinite time frame.
2. In the event that a freeze is requested in the middle of a month, the member will only be entitled to refund if the cause of the freeze is due to death or disability.
3. A freeze on a membership will last until the member notifies RehabFit staff that they would like to resume membership.
4. Should a member identify that they want to freeze their membership for a set time frame, the membership will be frozen at that specified time frame. Should the member fail to return or contact us informing us to remove the freeze, the membership will be adjusted to continue on freeze and the member will not be charged. Charging will resume once the member identifies they would like to resume their membership.

RehabFit

RESTRICTIONS ON CANCELLATION OR ASSIGNMENT

All Member's failure to use the membership or facilities does not relieve a Member of his or her liability for payment hereunder other than as described above. The membership is absolutely nontransferable, non-assignable, non-refundable and non-cancellable, except as provided in this agreement.

RehabFit will identify any member that hasn't used the gym for a period of 3 months and as a courtesy communicate by email and mail to inform them. At that time, a courtesy freeze will be placed. If no communication is received for 30 days, the membership will be cancelled.

EQUAL OPPORTUNITY POLICY STATEMENT

RehabFIT seeks, enrolls and maintains memberships without regard to race, religious creed, color, national origin, ancestry, physical disability, mental condition, marital status, sex, sexual orientation or age. All Members have full and equal access to the facility. All Members with disabilities may request reasonable accommodations for their physical and mental impairments. Reasonable accommodations will be provided.

WARNING

If you have a history of heart-related disease, you should consult a physician before purchasing a membership. RehabFIT urges all Members to obtain a physical examination from their physicians prior to the use of any equipment or attendance in any exercise or aerobic classes.

LAW APPLICABLE

New Hampshire Health Club Law, RSA 358-I governs this membership contract.

INVALID PROVISION

The provisions of this membership contract are severable. If any provision of this contract is declared to be void, invalid or unenforceable, it is the intention of all parties to this contract that the remainder of the contract will remain valid and enforceable.

NO WAIVER OF RIGHTS

RehabFIT does not waive the right to have future payments made when due if RehabFIT accepts a late or partial payment or delays in the enforcement of its rights on any occasions.

DEFAULT

A Member is in default if:

(a) RehabFIT does not receive the monthly payment from the Member on or before the date it is due, or

(b) A Member fails to fulfill any obligations or promises under this membership Contract including, but not limited to, compliance with the rules and regulations RehabFIT may set for use of the facility.

ATTORNEY'S FEES AND COURT COST

If a Member's failure to pay a membership installment due under this agreement results in RehabFIT retaining an attorney for collection, the Member shall be responsible for the payment of additional processing fees, court costs and reasonable attorney's fees.

RULES AND REGULATIONS

A violation of the posted rules and regulations may cause a Member's membership to be immediately revoked or terminated at the discretion of RehabFIT. In the event of termination of membership for rules violations, the Member's liability for any payments occurring after the date of the membership termination shall cease.

NON-SUFFICIENT FUNDS

Any Member who pays a membership fee by means of a check that is returned for non-sufficient funds will be assessed a fee of Twenty-Five Dollars ($25.00) plus the amount the check was written for to RehabFIT

MEMBER LIABILITY

It is specifically agreed that RehabFIT shall not be responsible or liable to the Member for articles lost or stolen. RehabFIT shall not be responsible or liable for loss or damage to any other property, of any Member by any other Member which property is the sole responsibility of the Member. Member agrees that he/she is responsible for any damages caused by member to the facilities and equipment, and for any personal injury or property damage caused by the Member to any other Member or to his/her property. Member further agrees to notify RehabFIT of any loss caused by the Member for which RehabFIT may be accused or held liable.

Edited 12/9/24 by Michelle Dow

PAR-Q+

The Physical Activity Readiness Questionnaire for Everyone

The health benefits of regular physical activity are clear; more people should engage in physical activity every day of the week. Participating in physical activity is very safe for MOST people. This questionnaire will tell you whether it is necessary for you to seek further advice from your doctor OR a qualified exercise professional before becoming more physically active.

GENERAL HEALTH QUESTIONS

Please read the 7 questions below carefully and answer each one honestly: check YES or NO.	**YES**	**NO**
1) Has your doctor ever said that you have a heart condition ☐ **OR** high blood pressure ☐?	☐	☐
2) Do you feel pain in your chest at rest, during your daily activities of living, **OR** when you do physical activity?	☐	☐
3) Do you lose balance because of dizziness **OR** have you lost consciousness in the last 12 months? Please answer **NO** if your dizziness was associated with over-breathing (including during vigorous exercise).	☐	☐
4) Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)? **PLEASE LIST CONDITION(S) HERE:** _____	☐	☐
5) Are you currently taking prescribed medications for a chronic medical condition? **PLEASE LIST CONDITION(S) AND MEDICATIONS HERE:** _____	☐	☐
6) Do you currently have (or have had within the past 12 months) a bone, joint, or soft tissue (muscle, ligament, or tendon) problem that could be made worse by becoming more physically active? Please answer **NO** if you had a problem in the past, but it **does not limit your current ability** to be physically active. **PLEASE LIST CONDITION(S) HERE:** _____	☐	☐
7) Has your doctor ever said that you should only do medically supervised physical activity?	☐	☐

☑ **If you answered NO to all of the questions above, you are cleared for physical activity.**
Please sign the PARTICIPANT DECLARATION. You do not need to complete Pages 2 and 3.

- Start becoming much more physically active – start slowly and build up gradually.
- Follow Global Physical Activity Guidelines for your age (https://www.who.int/publications/i/item/9789240015128).
- You may take part in a health and fitness appraisal.
- If you are over the age of 45 yr and NOT accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.
- If you have any further questions, contact a qualified exercise professional.

PARTICIPANT DECLARATION

If you are less than the legal age required for consent or require the assent of a care provider, your parent, guardian or care provider must also sign this form.

I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. I also acknowledge that the community/fitness center may retain a copy of this form for its records. In these instances, it will maintain the confidentiality of the same, complying with applicable law.

NAME _____ DATE _____

SIGNATURE _____ WITNESS _____

SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER _____

If you answered YES to one or more of the questions above, COMPLETE PAGES 2 AND 3.

⚠ Delay becoming more active if:

- You are currently experiencing a temporary illness, such as a cold or fever. It is best to wait until you feel better.
- You are pregnant. In this case, talk with your health care practitioner, physician, qualified exercise professional, and/or complete the ePARmed-X+ at www.eparmedx.com before becoming more physically active.
- Your health changes. Answer the questions on Pages 2 and 3 of this document and/or talk to your health care practitioner, physician, or qualified exercise professional before proceeding with any physical activity program.

01-11-2023

PAR-Q+

FOLLOW-UP QUESTIONS ABOUT YOUR MEDICAL CONDITION(S)

1. Do you have Arthritis, Osteoporosis, or Back Problems?

If the above condition(s) is/are present, answer questions 1a-1c If **NO** ☐ go to question 2

1a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
1b.	Do you have joint problems causing pain, a recent fracture or fracture caused by osteoporosis or cancer, displaced vertebra (e.g., spondylolisthesis), and/or spondylolysis/pars defect (a crack in the bony ring on the back of the spinal column)?	YES ☐ NO ☐
1c.	Have you had steroid injections or taken steroid tablets regularly for more than 3 months?	YES ☐ NO ☐

2. Do you currently have Cancer of any kind?

If the above condition(s) is/are present, answer questions 2a-2b If **NO** ☐ go to question 3

2a.	Does your cancer diagnosis include any of the following types: lung/bronchogenic, multiple myeloma (cancer of plasma cells), head, and/or neck?	YES ☐ NO ☐
2b.	Are you currently receiving cancer therapy (such as chemotheraphy or radiotherapy)?	YES ☐ NO ☐

3. Do you have a Heart or Cardiovascular Condition? This includes Coronary Artery Disease, Heart Failure, Diagnosed Abnormality of Heart Rhythm

If the above condition(s) is/are present, answer questions 3a-3d If **NO** ☐ go to question 4

3a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
3b.	Do you have an irregular heart beat that requires medical management? (e.g., atrial fibrillation, premature ventricular contraction)	YES ☐ NO ☐
3c.	Do you have chronic heart failure?	YES ☐ NO ☐
3d.	Do you have diagnosed coronary artery (cardiovascular) disease and have not participated in regular physical activity in the last 2 months?	YES ☐ NO ☐

4. Do you currently have High Blood Pressure?

If the above condition(s) is/are present, answer questions 4a-4b If **NO** ☐ go to question 5

4a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
4b.	Do you have a resting blood pressure equal to or greater than 160/90 mmHg with or without medication? (Answer **YES** if you do not know your resting blood pressure)	YES ☐ NO ☐

5. Do you have any Metabolic Conditions? This includes Type 1 Diabetes, Type 2 Diabetes, Pre-Diabetes

If the above condition(s) is/are present, answer questions 5a-5e If **NO** ☐ go to question 6

5a.	Do you often have difficulty controlling your blood sugar levels with foods, medications, or other physician-prescribed therapies?	YES ☐ NO ☐
5b.	Do you often suffer from signs and symptoms of low blood sugar (hypoglycemia) following exercise and/or during activities of daily living? Signs of hypoglycemia may include shakiness, nervousness, unusual irritability, abnormal sweating, dizziness or light-headedness, mental confusion, difficulty speaking, weakness, or sleepiness.	YES ☐ NO ☐
5c.	Do you have any signs or symptoms of diabetes complications such as heart or vascular disease and/or complications affecting your eyes, kidneys, **OR** the sensation in your toes and feet?	YES ☐ NO ☐
5d.	Do you have other metabolic conditions (such as current pregnancy-related diabetes, chronic kidney disease, or liver problems)?	YES ☐ NO ☐
5e.	Are you planning to engage in what for you is unusually high (or vigorous) intensity exercise in the near future?	YES ☐ NO ☐

PAR-Q+

6. **Do you have any Mental Health Problems or Learning Difficulties?** This includes Alzheimer's, Dementia, Depression, Anxiety Disorder, Eating Disorder, Psychotic Disorder, Intellectual Disability, Down Syndrome

If the above condition(s) is/are present, answer questions 6a-6b If **NO** ☐ go to question 7

6a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
6b.	Do you have Down Syndrome **AND** back problems affecting nerves or muscles?	YES ☐ NO ☐

7. **Do you have a Respiratory Disease?** *This includes Chronic Obstructive Pulmonary Disease, Asthma, Pulmonary High Blood Pressure*

If the above condition(s) is/are present, answer questions 7a-7d If **NO** ☐ go to question 8

7a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
7b.	Has your doctor ever said your blood oxygen level is low at rest or during exercise and/or that you require supplemental oxygen therapy?	YES ☐ NO ☐
7c.	If asthmatic, do you currently have symptoms of chest tightness, wheezing, laboured breathing, consistent cough (more than 2 days/week), or have you used your rescue medication more than twice in the last week?	YES ☐ NO ☐
7d.	Has your doctor ever said you have high blood pressure in the blood vessels of your lungs?	YES ☐ NO ☐

8. **Do you have a Spinal Cord Injury?** *This includes Tetraplegia and Paraplegia*

If the above condition(s) is/are present, answer questions 8a-8c If **NO** ☐ go to question 9

8a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
8b.	Do you commonly exhibit low resting blood pressure significant enough to cause dizziness, light-headedness, and/or fainting?	YES ☐ NO ☐
8c.	Has your physician indicated that you exhibit sudden bouts of high blood pressure (known as Autonomic Dysreflexia)?	YES ☐ NO ☐

9. **Have you had a Stroke?** *This includes Transient Ischemic Attack (TIA) or Cerebrovascular Event*

If the above condition(s) is/are present, answer questions 9a-9c If **NO** ☐ go to question 10

9a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
9b.	Do you have any impairment in walking or mobility?	YES ☐ NO ☐
9c.	Have you experienced a stroke or impairment in nerves or muscles in the past 6 months?	YES ☐ NO ☐

10. **Do you have any other medical condition not listed above or do you have two or more medical conditions?**

If you have other medical conditions, answer questions 10a-10c If **NO** ☐ read the Page 4 recommendations

10a.	Have you experienced a blackout, fainted, or lost consciousness as a result of a head injury within the last 12 months **OR** have you had a diagnosed concussion within the last 12 months?	YES ☐ NO ☐
10b.	Do you have a medical condition that is not listed (such as epilepsy, neurological conditions, kidney problems)?	YES ☐ NO ☐
10c.	Do you currently live with two or more medical conditions?	YES ☐ NO ☐

PLEASE LIST YOUR MEDICAL CONDITION(S) AND ANY RELATED MEDICATIONS HERE: _____

_____

GO to Page 4 for recommendations about your current medical condition(s) and sign the PARTICIPANT DECLARATION.

PAR-Q+

If you answered NO to all of the FOLLOW-UP questions (pgs. 2-3) about your medical condition, you are ready to become more physically active - sign the PARTICIPANT DECLARATION below:

- It is advised that you consult a qualified exercise professional to help you develop a safe and effective physical activity plan to meet your health needs.
- You are encouraged to start slowly and build up gradually - 20 to 60 minutes of low to moderate intensity exercise, 3-5 days per week including aerobic and muscle strengthening exercises.
- As you progress, you should aim to accumulate 150 minutes or more of moderate intensity physical activity per week.
- If you are over the age of 45 yr and **NOT** accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.

If you answered **YES** to **one or more of the follow-up questions** about your medical condition:

You should seek further information before becoming more physically active or engaging in a fitness appraisal. You should complete the specially designed online screening and exercise recommendations program - the **ePARmed-X+ at www.eparmedx.com** and/or visit a qualified exercise professional to work through the ePARmed-X+ and for further information.

⚠ Delay becoming more active if:

- You are currently experiencing a temporary illness, such as a cold or fever. It is best to wait until you feel better.
- You are pregnant. In this case, talk to your health care practitioner, physician, qualified exercise professional, and/or complete the ePARmed-X+ at www.eparmedx.com before becoming more physically active.
- Your health changes. Talk to your health care practitioner, physician, or qualified exercise professional before continuing with any physical activity program.

- You are encouraged to photocopy the PAR-Q+. You must use the entire questionnaire and NO changes are permitted.
- The authors, the PAR-Q+ Collaboration, partner organizations, and their agents assume no liability for persons who undertake physical activity and/or make use of the PAR-Q+ or ePARmed-X+. If in doubt after completing the questionnaire, consult your doctor prior to physical activity.

PARTICIPANT DECLARATION

- All persons who have completed the PAR-Q+ please read and sign the declaration below.
- If you are less than the legal age required for consent or require the assent of a care provider, your parent, guardian or care provider must also sign this form.

I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. I also acknowledge that the community/fitness center may retain a copy of this form for records. In these instances, it will maintain the confidentiality of the same, complying with applicable law.

NAME _____ DATE _____

SIGNATURE _____ WITNESS _____

SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER _____

For more information, please contact

www.eparmedx.com
Email: eparmedx@gmail.com

Citation for PAR-Q+
Warburton DER, Jamnik VK, Bredin SSD, and Gledhill N on behalf of the PAR-Q+ Collaboration. The Physical Activity Readiness Questionnaire for Everyone (PAR-Q+) and Electronic Physical Activity Readiness Medical Examination (ePARmed-X+). Health & Fitness Journal of Canada 4(2):3-23, 2011.

The PAR-Q+ was created using the evidence-based AGREE process (1) by the PAR-Q+ Collaboration chaired by Dr. Darren E. R. Warburton with Dr. Norman Gledhill, Dr. Veronica Jamnik, and Dr. Donald C. McKenzie (2). Production of this document has been made possible through financial contributions from the Public Health Agency of Canada and the BC Ministry of Health Services. The views expressed herein do not necessarily represent the views of the Public Health Agency of Canada or the BC Ministry of Health Services.

Key References

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2. Warburton DER, Gledhill N, Jamnik VK, Bredin SSD, McKenzie DC, Stone J, Charlesworth S, and Shephard RJ. Evidence-based risk assessment and recommendations for physical activity clearance. Consensus Document. APNM 36(S1):S266-s298, 2011.
3. Chisholm DM, Collis ML, Kulak LL, Davenport W, and Gruber N. Physical activity readiness. British Columbia Medical Journal. 1975;17:375-378.
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01-11-2023