Annex C (Employee Wellness and Civilian Fitness Program Enrollment Packet) to OPORD 12-238: IMCOM Civilian Wellness, Enterprise Wide Metrics Collection (U)

Civilian Wellness and Civilian Fitness Program

(AR 600-63 Health Promotion)

Enrollment

Packet

Wellness Program Coordinator:

Matt Price – matthew.d.price14.naf@mail.mil

G1, HQ IMCOM

HQ IMCOM CIVILIAN FITNESS PROGRAM ENROLLMENT PACKET

Welcome to the HQ, IMCOM Civilian Wellness Program! We appreciate your interest and hope to make the process of enrolling in the program as simple as

possible. Please take a few minutes to acquaint yourself with the Enrollment Packet.

The Enrollment Packet is designed to complete all the steps necessary to enroll DA Civilians in the Civilian Wellness Program. It is important to note that you will not be enrolled in the program unless all paperwork is complete, you have received medical approval to start the program (if necessary) and you have provided the Wellness Office with the required data. When you are approved for the program you will receive an Enrollment Approval form.

Congratulations on taking the first step to getting **fit** and staying **fit!**

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If you have any questions regarding the Civilian Fitness Program process please contact the IMCOM Wellness Coordinator listed above.

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HQ IMCOM Civilian Wellness Contract

I, ____ (please print) hereby commit to 1 hour, 3x per week, for 6 months, of wellness. I will be focused on challenging my abilities in the pursuit of improved physical, mental, social, family and spiritual performance.

I realize this contract is made with the agreement of my supervisor and may be interrupted for immediate work requirements.

This contract is for special enrollment in a limited implementation Civilian Wellness program that is available specifically to the IMCOM Civilian employees. I understand that if I am on leave status, sick leave, or TDY during the 6 month period I cannot reschedule the missed event and will not be able to extend my enrollment. I am aware that I MUST utilize the ATAAPS code provided to me for accountability purposes.

The below named individual has volunteered to participate in a 6 Month, 3 hour per week wellness program under the guidance of the HQ IMCOM Wellness Program Office. The program may consist of exercise, walking groups, strengthening exercises, limited weight training exercises, other activities designed to improve individual wellness levels, as well as individually directed fitness activities. In order to participate, a supervisor's signature is required.

Participant Name (Please Print):____

Participants Signature: _________________________________ Date: ______________

I agree to and approve the participation in a scheduled fitness program.

Supervisor's Signature: _______________________________Date:________________

	Monday	Tuesday	Wednesday	Thursday	Friday
Day					
Time					

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Physical Fitness Program Release/ Waiver of Liability

I know that participating in a physical fitness program can be a potentially hazardous activity. I will not enter this program unless I am medically fit. I assume all risks associated with participating in this program, including, but not limited to injuries related to falls, heart attack, stroke, heat related injuries, contact with other participants, infectious diseases, and equipment conditions.

In consideration of the opportunity to participate in the physical fitness program, I UNDERSTAND AND DO HEREBY AGREE TO ASSUME ALL OF THE ABOVE RISKS AND OTHER RELATED RISKS WHICH MAY BE ENCOUNTERED IN SAID PHYSICAL FITNESS PROGRAM. I do hereby agree to hold the United States Government, its officials, and personnel harmless from any and all liability, actions, cause of actions, claims, expenses, and damages on account of injury to my person or property, even injury resulting in death, which I now have or which may arise in the future in connection with my participation in any other associated activities of the Physical Fitness Program [release and waiver of liability does not prevent me from receiving available emergency medical care or medically-related entitlements routinely available to me if I am military/family member or federal employee.]

I expressly agree that this release, waiver and indemnity agreement is intended to be as broad and inclusive as permitted by the law of the applicable State, and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect. This release contains the entire agreement between the two parties hereto and the terms of this release are contractual and not a mere recital.

I further state that I HAVE CAREFULLY READ THE FOREGOING RELEASE AND KNOW THE CONTENTS THEREOF AND I SIGN THIS RELASE AS MY OWN FREE ACT. This is a legally binding document which I have read and understand.

Print Name: ____

Signature: ____

Date: ____________________________

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Required Assessment Data

Participants Name: ____

Initial____________ Mid_____________ End_____________

Height: FT_______' IN ________"

Weight:_______ LBS Weight:_______ LBS Weight:_______ LBS

BP ______ / ______ BP ______ / ______ BP ______ / ______

RHR _______ BPM RHR _______ BPM RHR _______ BPM

BMI____________ BMI____________ BMI____________

Smoker YES / NO

Activity Level: *(Check one below)*

Active: ______ Sedentary: ______

Goals
-
-
-
-
-
-
-

Physical limits.
-
-
-
-
-

Last workout prog.
-

Days a week
-

Duration
-

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Personal Readiness Assessment

Below are items that you should consider BEFORE beginning an exercise program. Your physical activity readiness is a first step when planning to increase physical activity levels in your life and is for your personal use only.

Although these serve as a basic guideline, should you have any questions you should consult a physician BEFORE beginning an exercise program:

Has a physician ever said you have a heart condition and you should only do physical activity recommended by a physician?	Yes/No
When you do physical activity, do you feel pain in your chest?	Yes/No
When you were not doing physical activity, have you had chest pain in the past month?	Yes/No
Do you ever lose consciousness or do you lose your balance because of dizziness?	Yes/No
Do you have a joint or bone problem that may be made worse by a change in your physical activity?	Yes/No
Is a physician currently prescribing medications for your blood pressure or heart condition?	Yes/No
Are you pregnant?	Yes/No
Do you have insulin dependent diabetes?	Yes/No
Are you 69 years of age or older?	Yes/No
Do you know of any other reason you should not exercise or increase your physical activity?	Yes/No

If you answered 'YES' to any of the above questions, talk with your doctor **BEFORE** you become more physically active. Tell your doctor your intent to exercise and to which questions you answered yes.

If you honestly answered 'NO' to all questions, you can be reasonably positive that you can safely increase your level of physical activity **gradually**.

If your health should change so that you can then answer 'YES' to any of the above questions, seek guidance from a physician immediately.

MEDICAL APPROVAL BY HEALTH CARE PROVIDER

Patient Name (print): ___________________________ Phone: ___________________

has medical approval to participate in the physical fitness component of the Civilian Fitness Program. I understand that the program includes mild to moderate intensity exercise, and may be conducted in unsupervised groups or individually. I also understand that participation is voluntary, allowing the participant to stop and rest at **any** time he or she desires. Participants will be authorized to exercise at or near the fitness facility on their installation.

If the participant is restricted from performing certain exercises, please list restrictions and suitable exercises that may be substituted in the space provided below.

The following exercise restrictions and substitutions apply (if none, so state):

____

____

____

____

Health Care Provider's Signature: _____________________________ Date_________

Provider's Print Name/Stamp: _________________________________

Office telephone number: _______________________

Email Address: _______________________________

Participant: If you answered "YES" to any of the ten key questions on page 4, this form must be completed by your healthcare provider prior to beginning the program.

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PARTICIPANT ENROLLMENT APPROVAL FORM

__________________________has applied to participate in the IMCOM Civilian Wellness, Enterprise-wide Metrics Collection Study for six months. The participant's application has been reviewed and are (only circled letters **apply):**

A) Accepted **into the Civilian Wellness Program.** All documentation has been received and the Civilian Fitness Assessment is complete.

B) Not approved to continue the program until the Civilian Fitness Coordinator receives the **Supervisor's Signature on the Participation Agreement.**

C) Not approved to continue the program until the Civilian Fitness Coordinator receives the **Health Care Provider's Approval** signed by a Health Care Provider.

The program starts for the participant on an agreed upon date and will end 6 months later. Participants are required to submit a Final Civilian Fitness Questionnaire in order to complete the program and be eligible to receive the Civilian Wellness and Civilian Fitness Program certificate.

Participants will be sent the Final Questionnaire by the IMCOM Civilian Wellness Coordinator upon completion of the 6 month program. **Participants must complete the Final Questionnaire in order to complete the program.**

Program started on: _______________ Program will end on: __________________
(End Date 6 mo. later)

DATE: ___________ SIGNATURE: ____________________________________
Matthew Price - Wellness Coordinator