

# Burke Fitness Center

*Thank you for considering Burke in making fitness a part of your life!*

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The Burke Fitness Center is located in the [Sports Center](#).

The Burke Fitness Center is open to the public. Members of the community, as well as current and prior patients at Burke Rehabilitation Hospital – all are welcome to participate in our programs.

The Burke Fitness Center provides exercise experiences for members ages 40 and over who want to improve and maintain overall health and wellness. The fitness center welcomes recent graduates of physical therapy and cardiac rehabilitation, and those with ongoing medical issues including pulmonary disorders, neurological (such as stroke and Parkinson’s disease) and orthopedic pathologies. We welcome individuals who use assistive devices.

Our trainers are specialists who have earned degrees in Exercise Science and/or are certified by nationally recognized and accredited agencies including, but not limited to, the American College of Sports Medicine, National Strength and Conditioning Association, and National Academy of Sports Medicine.

Requirements for membership:

- Medical clearance completed by your physician. ([See page 13](#))
- If you were recently discharged from physical therapy, ask your therapist for recommendations and precautions for post-rehabilitation exercises to share with our trainers. Alternatively, bring your personalized at-home exercise plan with you to your Initial Personal Training Session.

Important Information:

- Physical therapy is not offered through the Fitness Center. However, Burke Rehabilitation Hospital does provide outpatient physical therapy at the White Plains campus as well as at off-site Burke facilities.
- Individuals with balance or cognitive limitations are welcome but may need assistance. In this case, he/she will be required to bring a caregiver to assist them for the duration of their exercise sessions. Burke reserves the right to determine whether a participant requires a caregiver present while exercising at the fitness center.

## Enrollment Process

1. Complete pages 4-12.
2. Ask your physician to complete the *Physician Approval and Recommendations*, [page 13](#).
3. Return all forms to the Burke Fitness Center.
  - **E-mail:** [burkefitness@burke.org](mailto:burkefitness@burke.org)
  - **Address:** Burke Rehabilitation Hospital  
Attn: Burke Fitness Center  
785 Mamaroneck Ave.  
White Plains, NY 10605
  - **Fax:** 914-597-2809
4. The fitness center will call you to schedule your initial personal training session when all of the forms have been received.

## Reservation System

1. Open gym sessions must be reserved prior to coming to the gym.
2. Open gym reservations can be made through the Technogym app\*, online, at the kiosk, by calling the fitness center directly, or emailing [burkefitness@burke.org](mailto:burkefitness@burke.org).
3. The Technogym app is available on smartphones.
4. Members may reserve a maximum of three open gym sessions at a time.
5. Maximum capacity in open gym sessions is 28 members. You may sign up for the waiting list if the desired session is full.

**\*Your trainer will walk you through downloading the Technogym app and making reservations at your Initial Personal Training session.**

## Check-in

Upon entering the Sports Center, you will be asked to:

1. Scan in with your fitness center scan card.
2. Wait until your session begins. Please avoid arriving early as space is limited.
3. Please exit by the end of your session time.

## Hours of Operation

Monday through Friday: 8:00 AM – 4:30 PM

### Sessions

8:00 AM – 9:15 AM

9:15 AM – 10:30 PM

10:30 PM – 11:45 PM

12:45 PM – 2:00 PM

2:00 PM – 3:15 PM

3:15 PM – 4:30 PM

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**Allowed capacity per session: 28 people.**

# Personal Health History Form

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_ Gender: \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Referred by: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**Please Select All Known Health Conditions That May Apply**

Cardiovascular		Date	Musculoskeletal		Date
<input type="checkbox"/>	Chest Discomfort		<input type="checkbox"/>	Ankle Swelling	
<input type="checkbox"/>	Current Heart Murmur		<input type="checkbox"/>	Back Issues	
<input type="checkbox"/>	Extra, Skipped or Rapid Heart beat		<input type="checkbox"/>	Broken Bones (Recent ≤ 1 yr)	
<input type="checkbox"/>	Heart Attack		<input type="checkbox"/>	Fibromyalgia	
<input type="checkbox"/>	High Blood Pressure		<input type="checkbox"/>	Foot Issues	
<input type="checkbox"/>	High Cholesterol		<input type="checkbox"/>	Limited Motion in Joints	
<input type="checkbox"/>	Low Blood Pressure		<input type="checkbox"/>	Lupus	
<input type="checkbox"/>	Peripheral Vascular Disease		<input type="checkbox"/>	Neck Issues	
<input type="checkbox"/>	Phlebitis or Emboli		<input type="checkbox"/>	Osteoarthritis	
<input type="checkbox"/>	Coronary Artery Bypass Surgery		<input type="checkbox"/>	Osteoporosis	
<input type="checkbox"/>	Stroke		<input type="checkbox"/>	Rheumatoid Arthritis	
<input type="checkbox"/>	Pacemaker or Defibrillator		<input type="checkbox"/>	Shoulder Issues	
<input type="checkbox"/>	Cardiovascular Surgery		<input type="checkbox"/>	Knee Issues	
<input type="checkbox"/>	Congenital Heart Disease		<input type="checkbox"/>	Swollen, Sore, Painful Joints	
<input type="checkbox"/>	Atrial Fibrillation		<input type="checkbox"/>	Multiple Sclerosis	
<input type="checkbox"/>	Aneurysm		<input type="checkbox"/>	Amputation	
<input type="checkbox"/>	Heart Transplant		<input type="checkbox"/>	Peripheral Neuropathy	
<input type="checkbox"/>	Heart Valve Disease		<input type="checkbox"/>	Parkinson's Disease	
<input type="checkbox"/>	Coronary Angioplasty/Stents		<input type="checkbox"/>	Cerebral Palsy	
<input type="checkbox"/>	Aortic Stenosis		<b>Other</b>		
<input type="checkbox"/>	Congestive Heart Failure		<input type="checkbox"/>	Diabetes	
<b>Pulmonary</b>			<input type="checkbox"/>	Mental Health Issue	
<input type="checkbox"/>	Allergies		<input type="checkbox"/>	Meniere's/Vestibular/Vertigo	
<input type="checkbox"/>	Asthma		<input type="checkbox"/>	Epilepsy or Seizures	
<input type="checkbox"/>	Emphysema		<input type="checkbox"/>	Hearing or Vision Impairment	
<input type="checkbox"/>	Bronchitis or Chronic Bronchitis		<input type="checkbox"/>	Voice/Speech Impairment	
<input type="checkbox"/>	Pulmonary Embolism		<input type="checkbox"/>	Chronic Liver or Kidney Disease	
<input type="checkbox"/>	Cystic Fibrosis		<input type="checkbox"/>	Cancer historic	
<input type="checkbox"/>	Pneumonia		<input type="checkbox"/>	Cancer current	
<input type="checkbox"/>	Pulmonary Edema		<input type="checkbox"/>	Pregnant/Post-Natal	
<input type="checkbox"/>	Pulmonary Hypertension		<input type="checkbox"/>	Traumatic Brain Injury	
<input type="checkbox"/>	Oxygen Therapy (_____ L/min.)		<input type="checkbox"/>	Dementia / Alzheimer's	

## Personal Health History *(continued)*

Please list any recent surgery, medical procedures or hospitalizations:

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Please answer the following questions.

	Yes	No
Do you have a caregiver or home health aide who will attend the program with you?		
Have you fallen within the past 12 months?		
Do you worry about falling or feeling unstable when walking?		
Do you use or have you been advised to use an assistive device to get around safely? If yes, please list the assistive device you are currently using (walker, wheelchair, cane, prosthetic, crutches, etc.)		
<b>Assistive Device:</b> _____ <b>Date:</b> _____		

Please check the appropriate column describing your ability to perform each task or activity.

	No Difficulty	Some Difficulty	Cannot perform
Getting up from a chair			
Climbing stairs			
Walking short distances			
Stepping onto a curb			
Lying down flat on back			
Getting up from the floor			

Please check the appropriate column describing any impairment of movement in each body part.

	Yes	No	Right	Left
Head/neck				
Shoulder				
Upper extremity				
Hips/pelvis				
Lower extremity				
Trunk				

## Personal Health History *(continued)*

RISK FACTOR	ACSM RISK FACTOR DEFINING CRITERIA	YES	NO	NOT SURE
Age	Are you a male over the age of 55 or a female over the age of 65?			
Family History	Has there been a heart attack, coronary bypass, or sudden death before age 55 in father or male first-degree relative (i.e. brother or son) or in mother before age 65 or other female first degree relative (i.e. sister or daughter)?			
Cigarette Smoking	Are you a current cigarette smoker or have you quit within the previous 6 months?			
High Cholesterol (Dyslipidemia)	Has your doctor prescribed medication to lower your cholesterol?			
Fasting Glucose	Have there been any abnormal fasting glucose measurements on at least 2 separate occasions?			
Obesity	Is your waistline over 40 inches if you are male or 35 inches if you are female?			
High Blood Pressure	Has your doctor prescribed medication to control your blood pressure, or, have you had a blood pressure measurement over 140/90 on at least 2 separate occasions?			
Sedentary Lifestyle	Are you participating in a regular exercise program or do you participate in 30 minutes of aerobic activity most days of the week?			
<b>HAVE YOU HAD ANY OF THE FOLLOWING SYMPTOMS RECENTLY?</b>		<b>YES</b>	<b>NO</b>	<b>NOT SURE</b>
Pain, discomfort in the chest, neck, jaw, arms or other areas during exertion?				
Shortness of breath during rest or mild exertion?				
Dizziness?				
Rapid extra heart beats you can feel?				
Significant pain in the lower legs at rest or mild activity (pain level makes you stop)?				
Ankle Swelling?				
Do you have a known heart murmur?				
Unusual fatigue or shortness of breath with usual activities?				

Height \_\_\_\_\_ Weight \_\_\_\_\_

## Personal Health History *(continued)*

Please list any medications and dietary supplements you are taking.

- |          |          |          |
|----------|----------|----------|
| 1. _____ | 4. _____ | 7. _____ |
| 2. _____ | 5. _____ | 8. _____ |
| 3. _____ | 6. _____ | 9. _____ |

Have you experienced any complications from any of the aforementioned conditions which may be aggravated by exercise? If yes, please explain briefly:

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Do you have a joint replacement?  Yes  No Date: \_\_\_\_\_

If yes, which joint has been replaced? Joint: \_\_\_\_\_  Right  Left

Please list any restrictions or guidelines due to the joint replacement:

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Tell us about your history with exercise, physical activity, and overall wellness. Why are you interested in a wellness program like Burke Fitness Center?

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What is your main objective with training?

*(Please check one and specify)*

I want to achieve a goal:

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I want to improve my sport performance:

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Healing a health disorder:

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How many times per week do you want to train?

1 per week

3 per week

2 per week

4 or more per week

For how long have you been training until today?

A little/no training

Since at least 3 months

Since at least 6 months

How much time do you have to train?

Up to 30 minutes

Up to 1 hour

Up to 45 minutes

More than 1 hour

# Community Wellness Exercise Program Liability Waiver

I, \_\_\_\_\_, wish to join a community wellness exercise program at the Burke Rehabilitation Hospital. I understand that exercising in this program may involve a variety of physical activities including, but not limited to stretching, strengthening with weight training machines and devices, exercising on motorized and non-motorized exercise machines, and walking within the Burke Rehabilitation Hospital grounds. I understand that participation in this program is voluntary and not medically prescribed therapy.

I realize that the reaction of one's body to physical activity cannot be predicted with complete accuracy. There can be abnormal physical responses including, but not limited to, changes in blood pressure or heart rate, dizziness and in rare cases, serious illness such as heart attack. There is some risk of injury to bones, joints, and/or muscles. There is some risk of viral and bacterial illness such as communicable diseases (MRSA, influenza, and COVID-19). I am willing to assume such risk. My physician approves of my participation in this program.

In consideration of my participation in the Burke Rehabilitation Hospital Community Wellness Exercise Programs, I for myself, my heirs, executors, administrators, representatives and assigns hereby discharge The Burke Rehabilitation Hospital, its employees, subsidiaries, affiliates, offices, directors, agents, successors, assigns, and/or representatives, from any and all claims, demands, causes of action, suits, charges, liabilities, and expenses (including attorneys' fees) of any nature whatsoever, now or in the future, arising from my participation in these programs including but not limited to liability related to the injuries listed above, however caused, whether they occur during or after my participation in these programs.

I hereby affirm that I have read and fully understand the above, and that my signing of this waiver is knowing and voluntary.

Signature \_\_\_\_\_

Date \_\_\_\_\_

## MEMBERSHIP POLICIES

<b>MEMBERSHIP DUES</b>	Dues will be collected at the beginning of each month, for the prior month. Burke Fitness Center must be notified of ANY credit card changes immediately (i.e. new credit card, new account number, new expiration date, etc.) New memberships: The enrollment fee and first month’s membership fee will be charged to the member’s credit card in the month following the in-person Initial Personal Training. Dues for the first month of the membership will be prorated.
<b>MEMBERSHIP</b>	Members will enroll in Electronic Funds Transfer (EFT) at time of enrollment. An enrollment fee is required for all new members and memberships that have been expired for one year or more. All memberships are charged automatically monthly until a cancellation is received. <b>Cancellation:</b> Members may cancel, for any reason, with a 14-day written notice.
<b>CHECK-IN PROCEDURE</b>	All members are required to scan in at the Sports Center using their membership key tag. There is a \$5 charge for lost key tags. Members will use a fob to log into our Technogym equipment. There will be a \$15 charge for lost fobs.
<b>HOURS OF OPERATION</b>	The Burke Rehabilitation Hospital reserves the right to change its fitness center hours of operation for any reason, such as changes in member usage, maintenance repairs, community service activities, holidays, or government guidance.
<b>RATE CHANGE</b>	Monthly rates and all policies of the Burke Fitness Center are subject to change unless protected for set periods of time indicated within this agreement. A minimum 30-day notice in writing to all members will precede any change. Where automatic charges have been authorized, we will assume any rate changes are accepted by the member unless notified in writing.
<b>CHANGES IN MEDICAL STATUS</b>	We require that our members inform Burke Fitness Center of any changes in medical status that may impact participation in exercise. A <i>Medical Clearance for Returning to Exercise</i> , signed by your physician, will be required. Members are required to stay home if they are experiencing symptoms related to any illness, including COVID-19.
<b>MEMBERSHIP SUSPENSION OR TERMINATION BY BURKE ADULT FITNESS CENTER</b>	We reserve the right to suspend or terminate your membership, or any member on your membership, at any time for a failure to comply with these or any of our other rules, regulations, procedures, or policies (which may be amended as necessary), or for conduct we determine to be improper or contrary to our best interests. You may not be entitled to refund of dues paid.
<b>DEFAULT AND LATE PAYMENT</b>	Should you default on any payment obligation as called for in this agreement, the entire remaining balance shall be deemed due and payable upon demand, and you agree to pay allowable interest, and all cost of collection, including, but not limited to, collection agency fees, court costs and attorneys’ fees. Should any monthly payment become more than 10 days past due, you will be charged a late fee to cover additional administrative expenses and other expenses related to obtaining your payment. A fee will be charged for all returned payments.
<b>PAYMENT SUSPENSION</b>	Members may suspend their membership for any reason (medical, vacation, etc.) for a minimum of 30 days. Members must fill out and sign a <i>Payment Suspension Form</i> or email the request to <a href="mailto:burkefitness@burke.org">burkefitness@burke.org</a> The member will not be charged for the suspension period. Retroactive suspensions will be considered only with a doctor’s note and for a maximum of one month. If the member suspends for a medical reason; they must supply a medical clearance to return to exercise.
<b>ENTIRE AGREEMENT</b>	This agreement constitutes the entire and exclusive agreement between parties. Any promise, representation, understanding and/or agreement pertaining directly or indirectly to the agreement may be modified only by an instrument in writing. Employees are not authorized to make any independent agreements, which are not the center’s policy, with any member

## MEMBERSHIP RULES

Violation of these rules may be cause for suspension or cancellation of membership without refund.

- Members must scan in at the Sports Center upon entering the Fitness Center.
- Members are permitted into the fitness center only during their reserved open gym session. There is a **28-person capacity** (not including staff) in the fitness center at all times. Members may reserve 3 active bookings at the same time.
- Members are required to come dressed and prepared to workout. Open toe or open back shoes are not permitted. Athletic attire and shoes in good condition should be worn at all times during exercise sessions.
- Lockers are free to use to place loose items in.
- Members must enter and leave the fitness center at their scheduled open gym session time.
- Members are not permitted to start their workout or reserve machines prior to the beginning of a time slot.
- Any non-essential items should not be brought into the fitness center. Belongings may not be placed on the floor, on fitness equipment or on the windowsills.
- Proper hydration is essential before, during, and after exercise. Members are asked to bring in their own hydration. A touchless water dispenser is available in the fitness center. Water and all beverages must be in closed water bottles.
- No food is allowed in the fitness center.
- Windows and doors must remain closed.
- Equipment must be cleaned after each use with the wipes provided.
- If symptoms arise, the exercise must be terminated immediately. Symptoms include (but are not limited to):
  - Shortness of breath
  - Sharp pain
  - Dizziness
  - Blurred vision
  - Rapid Heart Beat
- Members are responsible for informing the staff of their past and present health information that may have an effect on their exercise program.
- Do not use any piece of equipment without prior instruction from staff.
- Only members, caregivers, and approved guests are allowed in the gym area. No children are allowed in the workout area.
- Use trash receptacles for all waste and wipes.
- Observe time limits on equipment when members are waiting:
  - Cardio equipment 25 minutes
  - Strength equipment 5 minutes
  - Platform tables 15 minutes

## MEMBERSHIP RULES (cont.)

- Do not use any piece of equipment if it appears damaged or broken. Please report any broken equipment to a staff member.
- Members are asked to bring their own towel.
- Members are responsible for keeping all appointment and/or reservation times. If a member is unable to keep their appointment for any reason, members are encouraged to cancel in advance to give other members the chance to book if they are on a waiting list. Members who do not attend a booked appointment and have not cancelled their booking will be considered no-shows and automatically given a strike. Members who accrue **3 strikes** within **90 days** must call to book open gym sessions until their strikes automatically expire after **14 days**.
- Members are expected to be courteous to each other and the staff. Courteous behavior includes, but is not limited to, appropriate language and gestures.

I agree to act in accordance with all of the member policies and facility rules of the Burke Fitness Center as publicized from time to time. I hereby affirm that I have read and fully understand the above and attached, and that my signing of this waiver is knowing and voluntary.

X

Member's Signature

Date

X

(Please print name)

# THE BURKE FITNESS CENTER AGREEMENT

**ALL MEMBERS MUST BE AT LEAST 40 YEARS OF AGE OR HAVE A QUALIFYING MEDICAL CONDITION**

Name \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_

## GYM MEMBERSHIP

\$85.00/month

*Plus* Initial Personal Training – \$80.00

Memberships function on a monthly basis; dues will be charged monthly until the member cancels.

**CREDIT CARD CHARGE WILL APPEAR ON YOUR STATEMENT UNDER WINIFRED MASTERSON BURKE REHABILITATION HOSPITAL**

CARD # \_\_\_\_\_ CVV# \_\_\_\_\_ EXP DATE \_\_\_\_\_

X  
\_\_\_\_\_  
Member Signature

\_\_\_\_\_  
Date

Patient's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

## **Physician Approval and Recommendations for Exercise**

*To be completed by your physician*

Your Patient \_\_\_\_\_ (Name of Participant) would like to participate in an exercise program at the Burke Fitness Center, a non-clinical fitness facility that provides a variety of cardiovascular, strength, flexibility and balance activities. **This is not physical therapy. This is an open gym.**

Vital signs: HR \_\_\_\_\_ BP \_\_\_\_\_ RR \_\_\_\_\_ SpO2 \_\_\_\_\_

**Please check one of the following:**

\_\_\_\_\_ **YES**, my patient is eligible to participate in an exercise program. My patient has no current unstable medical problems that are a contraindication to participating in an exercise program.

\_\_\_\_\_ **NO**, my patient is not eligible to participate in an exercise program due to his or her current medical status.

My patient's diagnosis (if applicable):

\_\_\_\_\_  
\_\_\_\_\_

My patient should observe the following restrictions and/or recommendations:

\_\_\_\_\_  
\_\_\_\_\_

### **Exercise Heart Rate Restrictions (Optional)**

Please restrict my patient from vigorous exercise.

Exercise heart rate range: \_\_\_\_\_ - \_\_\_\_\_ BPM; and/or not to exceed: \_\_\_\_\_ BPM

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Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE FAX COMPLETED FORM TO 914-597-2809**