Club Application
Club Partnership Application

APPLICANT INFORMATION

(TO BE ELIGIBLE, please attach a copy of legal certification or proof of legality of the business; this may be a tax form)

Business Name: ________________________________
EIN: __________________________________________

Physical Address: ____________________________________________

Office/Suite Number: __________________________________________
City, State: ________________________________ Zip: ________________

Mailing Address: If different from physical address.

Office/Suite Number: __________________________________________
City: ________________________________ State: ________________________________ Zip: ________________

Type of Business: (i.e. LLC, Sole Prop., Nonprofit) ________________________________ Date Established: _______ / _______ / _______

Owner’s Name: __________________________________________ Facility Manager’s Name: __________________________________________

Name of he/she managing this partnership:

Business’ Phone Number: ________________________________ Email: __________________________________________

(______)_______-_______________ ________________________________
Website: __________________________________________

Number of Current Employees To Date (If self-employed with no other employees, write 1):

____________________________________________________

Please provide a brief letter of the business, its mission, its services available and any special equipment, and why the business would be an asset to Health Possible Inc. Please give a detailed description of the location’s accessibility and any cleaning staff or services done in the facility (for example, having a maintenance and/or cleaning crew for a number of hours per day vs. outsourcing).
LIABILITY/INSURANCE
(Please attach a copy of proof of all insurance and/or liability coverage)

Insurance Provider:
__________________________________________________________________________

Date Insured: From ____________________ To: ____________________

Policy ID/Number: ____________________ Agent Name: ____________________

Insurance Address:
__________________________________________________________________________

City ____________________ State: ____________________ Zip: ____________________

Phone Number: ____________________ Agent Email: ____________________

(______)_______-__________
Agent Phone Number:

(______)_______-__________
Number of [this facility’s] Club Members (Round to the nearest 100):

____________________________
Membership Rates:

________, ________, ________, ________
List of Health & Fitness Services: (i.e. physical therapist, massage therapist, chiropractic, group classes)

____________________________
Health & Fitness Service Rates (use same order as services listed above):

________, ________, ________, ________, ________
Are you registered with IdeaFit?

Y N

Do you provide your professionals with access to free continuing education?

Y N If Yes, how? ____________________
Agreement to Monetary Rate

You must authorize this page to agree to abide by the given rates throughout the entire duration of your partnership, unless Health Possible Inc. deems and reports to your facility about price changes otherwise, in which you will have the right to renew your agreement at the time of said change(s). This agreement is breakable by either party at any time with 30 day notice for client reassignment and safety. Any attempt at compromising the rates provided without Health Possible Inc. Board of Directors’ authorized consent will lead to an immediate and permanent termination of the partnership and the immediate withdrawal of all HPI clients and funding. As clients are assigned, appropriate payments will be authorized at the beginning of each month on a month to month basis. Pre-paid cancelled and uncompleted appointments within 4 months of a client program require a return of correct payment to Health Possible Inc.

Rates Per Department

<table>
<thead>
<tr>
<th>Fitness</th>
<th>Group (All)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$20 per hour</td>
<td>$10 per hour</td>
</tr>
<tr>
<td>$10 per half hour</td>
<td>$5 per half hour</td>
</tr>
<tr>
<td>$10 monthly facility fee; to the facility owner(s)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nutrition</th>
<th>Special/Other (Any)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$30 per hour</td>
<td>$________ per hour</td>
</tr>
<tr>
<td>$15 per half hour</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental Health</th>
<th>$________ per half hour</th>
</tr>
</thead>
<tbody>
<tr>
<td>$30 per hour</td>
<td></td>
</tr>
<tr>
<td>$15 per half hour</td>
<td></td>
</tr>
</tbody>
</table>

Club Name: __________________________________________________________

Print Name: ___________________________ Signature: ___________________________

Your Title: ___________________________ Date: ___________________________

OFFICE USE ONLY:

HPI Administrator: ___________________________ Date: ___________________________
(Signature)

Health Possible Inc. | 3807 Peachtree Avenue | Suite 102 | Wilmington, North Carolina 28403
healthpossibleinc.org | sophia.aimone@healthpossibleinc.org