



## Healthy U Confidential Membership Form

Organization: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

1) Name: \_\_\_\_\_  
(Last) (First) (Middle Initial)

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

2) Gender:  Male  Female      3) Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

4) Background/Ethnicity: \_\_\_\_\_

5) Current Health Conditions (Please check all that apply):

Heart Disease    High Blood Pressure    Stroke    Arthritis

Diabetes    Kidney Disease   Other: \_\_\_\_\_

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