



MEMBERSHIP APPLICATION FORM

☐ NEW ENTRY

☐ RE ENTRY

PHOTO

ID NUMBER

PLEASE FILL THE APPLICATION IN BLOCK LETTERS

NAME			
NAME OF GUARDIAN			
ADDRESS: -		DOB	
		BLOOD GROUP	DO YOU LIKE TO DONATE YOUR BLOOD Y N
		AGE	
		PHONE NO	
EMAIL ADDRESS			
OCCUPATION		MAY WE ADD YOU IN OUR WHATSAPP GROUP Y N	
EMERGENCY NAME & CONTACT			
MENTION YOUR HEALTH CONDITION <i>PAST</i>		<i>PRESENT</i>	

YOUR TRAINING GOALS

OFFICE USE ONLY

SMOKER Y <input type="checkbox"/> N <input type="checkbox"/>	ALCOHOLIC
HEIGHT	WEIGHT
BMI	RHR

BMI RESULT:-

MEASUREMENT

CHEST	N	E
WAIST	U	L
THIGH	L	R
CALF	L	R
ARM	L	R

HOW MUCH WATER DO YOU DRINK DAILY?

HOW MANY TIME YOU TAKE FOOD DAILY?

RESTING TIME?

FOOD WEAKNESS?

DATE

BATCH TIME:-

ADMISSION FEE

JOINING FEE

SIGNATURE OF
THE APPLICANT:-

TRAINER:-

DIRECTOR:-