Welcome to the D-H Lebanon Fitness Rooms

Attached are the forms you need to complete.
Access to the fitness rooms located at Colburn Hill, DHMC Main Campus, Novell and Heater Road Clinic is granted based on primary work location.

1. Download the forms and save to your desktop.
2. Complete pages 2, 3, 4, 5 and 6.
3. If you answer "no" to all of the questions on page 3, then you may omit page 7.
4. If you answer "yes" to one or more of the questions on page 3, we recommend you share page 7 with your medical provider to receive fitness plan guidance and return to us.
5. Submit pages 2-6 or 2-7 to us for processing.
6. Email back to livewellworkwell@hitchcock.org.
   You may also choose to send your forms back to us by interoffice mail to "Live Well/ Work Well", or by fax attention to Wendy O'Connell at (603) 650-4881.

When processing is finalized, we will email you with pertinent information regarding use of the fitness room you have access to use. If you have not received your email access confirmation within five (5) business days please contact our office.

If you have questions please feel free to contact us at (603) 650-5950.

Sincerely,

The LWWW Employee Wellness Team

Dartmouth-Hitchcock Health | livewell workwell

EMPLOYEE WELLNESS | HEALTH IMPROVEMENT PROGRAM
employees.dartmouth-hitchcock.org/livewellworkwell.html

Dartmouth-Hitchcock Medical Center
One Medical Center Drive Lebanon, NH
03756-0001
Phone (603) 650-5950
Fax (603) 650-4881
livewellworkwell@hitchcock.org

Policy for Utilization of the D-H Lebanon Fitness Rooms

After reviewing this new policy, please sign below. Additional required forms are attached.

1. Masks are **required to be worn in all the fitness rooms,** regardless if you are alone or with others, including when you are exercising.
2. Maintain a minimum **physical distance**: **six feet (6')** at all times.
3. Please check the appropriate box (for the room you are requesting access to).
   - ☐ a. A maximum of **5** people will be allowed in the L2 Main Campus fitness room at one time.
   - ☐ b. A maximum of **4** people will be allowed in the Colburn Hill fitness space at one time.
   - ☐ c. A maximum of **5** people will be allowed in the Novell fitness room at one time.
   - ☐ d. A maximum of **3** people will be allowed in the Heater Road fitness room at one time.
     - i. This is a shared space with Rehab. Please note if a Therapist is in the space with a client, this will allow for only **one** employee exercising.
4. Machine sign ups are **required** and only available the day of use. One 30 minute time slot only per member on any given day.
5. Members are **required** to wipe down equipment with provided disinfectant wipes before and after use. Gloves will be provided and are recommended.
6. Use of the space is full carry in/carry out.
   a. This includes all personal items such as towels, clothing, badge, shoes/sneakers, etc. which are to be kept in a gym bag when in the fitness room. The use of lockers are not available at this time.
7. Sanitizing your hands is **required** before and after the use of the fitness room.
8. Hand sanitizer will be available for use.
9. Please bring your own water bottle. All water bubblers will be unavailable until further notice.
10. The badging in of anyone other than yourself is not allowed.
11. I have read, understand and agree to abide by the new policies as detailed in this agreement. I understand that failure to comply with the rules may result in the revocation of privileges to utilize the D-H Live Well/Work Well fitness rooms.

Name: _____ Department: _____

Signature: _____ Date: _____

☐ *Checking this button will constitute your electronic signature if submitted electronically*

Are you ready to increase your exercise or should you see your doctor first?

Physical Activity Readiness Questionnaire (PAR-Q)*

PLEASE PRINT

Name_____ Date _____

Department_____ Employer: ◯ D-H ◯ Conifer ◯ DC ◯ Other

For most people physical activity should not pose any problem or hazard. PAR-Q has been designed to identify adults for whom physical activity might be inappropriate or those who should have medical advice concerning the type of activity most suitable for them before beginning or changing their exercise program.

Please read carefully and answer yes or no to each question.

Common sense is your best guide in answering these questions.

QUESTION	YES	NO
Has your health care provider ever said you have heart trouble?	◯	◯
Do you frequently have pains in your heart and chest?	◯	◯
Do you often feel faint or have spells of severe dizziness?	◯	◯
Has a health care provider ever said your blood pressure was too high?	◯	◯
Has your health care provider ever told you that you have a bone or joint problem such as arthritis that has been aggravated by exercise, or might be made worse with exercise?	◯	◯
Is there a physical or other reason not mentioned here why you should not follow an activity program even if you wanted to?	◯	◯
Are you over age 65 and not accustomed to vigorous exercise that may increase your heart rate?	◯	◯

If you answered NO to all questions:

If you answered the PAR-Q accurately, you should have reasonable assurance of your present suitability for an exercise program.

If you answered YES to one or more questions:

Consult with your personal health care provider by telephone or in person before increasing your physical activity. We have enclosed a medical release form on the next page for your convenience.

Clear form

Updated form on based [8/16/21] edit for D-H and Conifer Use

Dartmouth-Hitchcock Health | livewell workwell
EMPLOYEE WELLNESS | HEALTH IMPROVEMENT PROGRAM
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INFORMED CONSENT AGREEMENT and RELEASE OF LIABILITY

For Utilization of the Live Well/Work Well Fitness Rooms and Exercise Programs

PLEASE PRINT NEATLY:

Name: _____ Email Address: _____

Your Employer: ○ D-H ○ Dartmouth College@DHMC ○ Conifer@DH Lebanon ○ Other: _____

Please check one: ○ Staff member ○ House Staff ○ Retiree ○ Volunteer

Department: _____ Work Contact Number: _____

Work Manager: _____ Work Location: _____

Select the Fitness Room you are requesting access to based on your primary work location:

○ Colburn Hill ○ Heater Rd ○ Main Campus, L2, Faulkner ○ Novell

ID BADGE# - This is located in the bottom right corner on the back of your work ID badge; your request cannot be processed without this ENTIRE number:

_____

Please insert your name or initials as requested.

1. I, _____, acknowledge and agree that I wish to voluntarily (i) participate in the activities and programs of the Live Well/Work Well program; and (ii) use the Live Well/Work Well program's facilities and equipment. Initials: _____

2. In consideration of being allowed to participate in the activities and programs of the Live Well/WorkWell program and to use its facilities and equipment, I, _____ waive, release and forever discharge the Live Well/Work Well program, Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital, operating jointly as "Dartmouth-Hitchcock" ("D-H"), and their affiliates, related entities,directors, officers, employees, agents, representatives, successors, and assigns from any and all responsibilities or liability from injuries or damages that result from my participation. Initials: _____

For Office Use Only	Completed by:	Date:
Submitted to Security		
Tracked in LWWW systems		

Dartmouth-Hitchcock Medical Center
One Medical Center Drive
Lebanon, NH 03756-0001
Phone (603) 650-5950
Fax (603) 650-4881
livewellworkwell@hitchcock.org

3. I agree on behalf of myself, and all my personal representatives, heirs, executors, administrators, agents, and assigns, to release and forever discharge D-H, and their affiliates, related entities, directors, officers, employees, agents, representatives, successors, and assigns, from any and all claims or causes of action, known or unknown, arising out of the negligence of D-H, whether active or passive, or any of its affiliates, directors, officers, employees, agents, representatives, successors, and assigns. This waiver and release of liability includes, without limitation, injuries or damages which may occur as a result of (a) my participation in any Live Well/Work Well program or class or use of any Live Well/Work Well facility or equipment; (b) negligent instruction or supervision, including, but not limited to, D-H or Live Well/Work Well program staff, personnel, or class/fitness instructors; (c) negligent hiring or retention of employees of D-H; (d) slipping, tripping, falling, or other bodily injury while on any portion of a Live Well/Work Well program facility including injuries resulting from D-H's or anyone else's negligent inspection or maintenance of any Live Well/Work Well facility or equipment; or (e) loss of personal property while participating in any Live Well/Work Well program or class or using any Live Well/Work Well facility or equipment. Initials: _____

4. I understand that strength, flexibility, and aerobic exercise, including the use of equipment, is a potentially hazardous activity and could carry the risk of potentially serious injuries or illness, death, loss or damage to personal property, or financial loss or theft. I understand that fitness activities involve a risk of injury and even death, and that I am voluntarily participating in these activities and using all LiveWell/Work Well facilities, equipment, and machinery with knowledge of the inherent dangers involved. I agree to voluntarily assume the full risk of any and all injury, death, damage, or loss of any kind arising out of my participation in any Live Well/Work Well program or use of any Live Well/Work Well facility or equipment. I further agree that I am responsible for my own personal belongings while attending any Live Well/Work Well program or using any Live Well/Work Well facility or equipment. Initials: _____

5. I FURTHER AGREE THAT IN PARTICIPATING IN ANY LIVE WELL/WORK WELL PROGRAM OR USING ANY LIVE WELL/WORK WELL FACILITY OR EQUIPMENT, I DO SO AT MY OWN RISK AND ASSUME THE RISK OF ANY AND ALL INJURY AND/OR DAMAGE I MAY SUFFER, WHETHER WHILE AT A LIVE WELL/WORK WELL FACILITY LOCATION OR NOT. THIS INCLUDES, BUT IS NOT LIMITED TO, INJURY OR DAMAGE I MAY SUSTAIN WHILE AND/OR RESULTING FROM USE OF A LIVE WELL/WORK WELL PROGRAM FACILITY, CLASS, OR EQUIPMENT, INCLUDING INJURIES OR DAMAGES ARISING OUT OF THE NEGLIGENCE OF D-H, WHETHER ACTIVE OR PASSIVE, OR ANY OF D-H'S AFFILIATES, EMPLOYEES, AGENTS,REPRESENTATIVES, SUCCESSORS, AND ASSIGNS. MY ASSUMPTION OF RISK INCLUDES, BUT IS NOT LIMITED TO, MY USE OF ANY LIVE WELL/WORK WELL PROGRAM FACILITY, CLASS, OR EQUIPMENT. I ASSUME THE RISK OF MY PARTICIPATION IN ANY ACTIVITY IN CONNECTION WITH LIVE WELL/ WORK WELL. Initials: _____

6. I agree and declare myself to be physically sound and suffering from no condition, impairment, disease, infirmity, or other illness that would prevent, or harm, my participation or use of equipment or machinery. Initials:_____

7. I acknowledge and agree that I have been informed of the possible need for a health care provider's approval for my participation in an exercise/fitness activity or in the use of exercise equipment and machinery. I agree to provide evidence of such approval upon the request of Live Well/Work Well. Initials: _____

8. I acknowledge and agree that it has been recommended that I have a yearly, or more frequent, physical examination and/or consultation with my health care provider as to physical activity, exercise, and the use of exercise and training equipment so that I might have his/her recommendations concerning my use of these fitness activities and equipment. Initials: _____.

9. I acknowledge and agree that I have read and completed the Physical Activity Readiness Questionnaire (PAR-Q) and if required have had a physical examination and been given my health care provider's permission to participate (and/or use Live Well/Work Well fitness equipment and facilities), or that I have decided to participate in activity and use of Live Well/Work Well facilities, equipment, and machinery without the approval of my health care provider and do hereby voluntarily assume all responsibility for my participation and/or activities, and utilization of equipment and machinery in my activities. ***Please check one:***

- ◯ I have completed *Are You Ready to Exercise?* (PAR-Q*)* form and do not require my health care provider's approval before beginning an exercise program and do hereby voluntarily assume all responsibility and risk for my decision and participation.

- ◯ I have completed *Are You Ready to Exercise?* (PAR-Q*)* and have received my health care provider's approval before beginning exercise and do hereby voluntarily assume all responsibility and risk for my decision and participation.

- ◯ I have decided to participate without my health care provider's knowledge and voluntarily assume all responsibility and risk for my decision and participation.

10. I understand that all D-H and Conifer policies and Codes of Conduct apply while I utilize the Live Well/Work Well program, the fitness room, its equipment, facilities, or the adjacent bathrooms. Failure to do so may constitute disciplinary action, including, without limitation, my suspension or termination of use of any Live Well/Work Well program, fitness room, equipment, or facilities. Initials: _____.

11. I have read, understand and agree to abide by all of the rules as detailed on this agreement. I understand that failure to comply with the rules may result in the revocation of privileges to utilize the Live Well/Work Well program fitness room or programs. Initials: _____.

_____ _____

Signature *Date*

☐ Checking this button will constitute your signature if submitted electronically

Send This Completed Form To Live Well/Work Well Employee Wellness:

Fax: 603-650-4881 Attention: Wendy O'Connell

Email: livewellworkwell@hitchcock.org

Submit Form Clear form

Dartmouth-Hitchcock Health | livewell workwell

EMPLOYEE WELLNESS | HEALTH IMPROVEMENT PROGRAM
employees.dartmouth-hitchcock.org/livewellworkwell.html

Dartmouth-Hitchcock Medical Center
One Medical Center Drive
Lebanon, NH 03756-0001
Phone (603) 650-5950
Fax (603) 650-4881
livewellworkwell@hitchcock.org

_____, 20_____

Dear Health Care Provider,

I have recently completed the Physical Activity and Readiness Questionnaire (PAR-Q) as directed by the staff of the Live Well/Work Well Employee Wellness department. Based on my responses, it has been suggested to have your support, guidance and approval before increasing or changing my activity level and engaging a physical fitness program using aerobic conditioning and strengthening equipment. LWWW may provide coaching, support, and personal training, however, most activity is voluntary, unsupervised exercise at home or at a worksite fitness room.

Thank you for your time in reviewing this matter. If you have any questions or concerns that you would like to discuss regarding this program, please feel free to contact Marion Cate, the Live Well/Work Well Employee Wellness Manager, at (603) 650-5950 or by email livewellworkwell@hitchcock.org.

Please review my health and functional status and indicate whether I have your consent to participate in a self-monitored activity/fitness program. Please identify any recommendations or restrictions that are appropriate for me in this exercise program (Please feel free to attach a letter detailing recommendations/ restrictions):

Patient Name: _____

- ○ No restrictions to exercise – has my approval to begin exercise program.
- ○ Able to participate, but prior to participation suggest completing a fitness evaluation for level/types of activityand specific recommendations.
- ○ Do not participate in unsupervised activity.
- ☐ My Other Recommendations:

MD Signature_____ **Date** _____

Please return a copy of this form to Live Well/Work Well:

Fax: (603) 650-4881 **Email:** livewellworkwell@hitchcock.org

Mail: D-H Live Well/Work Well Employee Wellness
Attention: Wendy O'Connell
One Medical Center Drive
Lebanon, NH 03756

Adapted from the Canadian Society for Exercise Physiology (Societe canadienne de physiologie de l'exercise– Revised 2002) Updated form on based [11/23/21] edit for D-H and Conifer Use

Clear form