

SHERMAN ISD EMPLOYEE MEMBERSHIP FORM

WITH

WNJ PASSPORT PLUS/SENIOR PASSPORT PLUS PROGRAM

500 N. Highland Avenue
Sherman, TX
(903) 813-TRIP
Passport Coordinator-Cheryl Brandon

NAME _____ PHONE _____ AGE _____

MAILING ADDRESS _____ CITY _____ ZIP _____

DATE OF BIRTH _____ EMPLOYEE ID# _____

(2) MEMBERSHIP TYPES: *SENIOR PASSPORT (AGES 55 AND OVER)

(CHECK ONE)

*SINGLE _____ (\$45/YEAR)

*MARRIED COUPLE _____ (\$60/YEAR)

*PASSPORT PLUS (AGES 18-54)

*SINGLE _____ (\$200/YEAR)

*MARRIED COUPLE _____ (\$400/YEAR)

(3) Spouse Information: NAME _____ D O B _____

CONTRACT TERMS: This is a contract between the applicant and Wilson N. Jones. The Sherman Independent School District's (SISD) sole responsibility will be to deduct the membership fee from the employee's paycheck and issue a check to Wilson N. Jones Medical Center once a month. This contract term is a (1) one year membership. Upon Termination of applicant's employment from SISD, applicant must contact Wilson N. Jones Passport Coordinator for payment arrangements. I understand that by signing that I have signed a twelve month contract and that no refunds will be made to me by the Wilson N. Jones or by SISD. Applicant by signing below agrees to abide by the rules and regulations set forth by Wilson N. Jones.

WAIVER: By signing below this member represents that they are in good Physical condition and able to use the equipment provided and the exercises recommended by Wilson N. Jones Medical Center. Member does hereby and forever release and discharge SISD and Wilson N. Jones Medical Center and all associated spas or facilities, their owners, employees and agents from any and all claims, demands, damages, rights of action, present or future, whether the same be known or unknown, anticipated or unanticipated, resulting from or arising out of the member's or his spouse's use or intended use of the said facilities and the equipment thereof. Member expressly discharges, waives and releases SISD, Wilson N. Jones Medical Center, employees and agent's acts or omissions of negligence. Member further waives, releases and discharges SISD, Wilson N. Jones Medical Center, employees and agents from liability arising from member's negligent acts or omissions.

AUTHORIZATION FOR PAYROLL DEDUCTION: I authorize my employer, SISD, to deduct the membership Fee from my wages in accordance with the company's payroll deduction plan. I understand that this amount will be deducted until the contract expires or until my employment with SISD, is terminated.

(4) SIGNATURE _____

DATE _____:

(5) Membership Total: \$ _____

(6) Monthly Deduction Amount: \$ _____