

Fitness & Wellness Standards — Full Guide

Complete criterion-by-criterion guidance: worked examples, first steps, common mistakes, implementation plans, and Monitor verification methods for all 51 criteria.

9 standards · 51 criteria · Version 4.0

ASF STANDARDS · FITNESS & WELLNESS · STANDARD 6

Standard 6 — Member Rights & Informed Consent

5 criteria · 4 non-negotiable · 1 core · Version 3.0

CRITERIA IN THIS STANDARD

6.1 — Waiver Language Is Genuinely Clear and Conspicuous, Not Hidden or Ambiguous

6.2 — Informed Consent Actively Corrects the Misconception That Exercise Is Inherently Safe

6.3 — Consent Scope Is Specific to the Actual Activity, Not Assumed to Cover Everything

6.4 — Minor Participation Follows the Legally Sound Consent Construction

6.5 — Members Can Genuinely Access and Review Their Own Signed Consent Documents

6.1 Waiver Language Is Genuinely Clear and Conspicuous, Not Hidden or Ambiguous

NON-NEGOTIABLE

Assumption-of-risk and liability release language is genuinely clear, conspicuous, and unambiguous — not buried within a longer document, written in dense legal language, or presented in a way that makes it easy for a member to sign without genuinely noticing what they're agreeing to.

In plain terms: The waiver's language about risk and liability is in plain words, clearly headed, in a size people can read — not buried in the membership agreement's fine print.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

A waiver that the member did not see, could not read, or did not understand is unlikely to hold up — and is unfair. Courts in many jurisdictions require assumption-of-risk and release language to be conspicuous: a clear heading ('Assumption of Risk and Release of Liability'), readable type, plain language, separated from the rest of the agreement, and specifically acknowledged (an initial or separate signature). This protects the facility legally and protects the member ethically: they know what they are agreeing to.

WHAT GOOD LOOKS LIKE

- Waiver language is genuinely conspicuous, not buried in a longer document.
- Language is genuinely clear and unambiguous, in plain terms.
- Members are given genuine, sufficient time to read before signing.

COMMON FAILURE MODES

- Key waiver language is buried within a longer document, easy to overlook.
- Language is dense legal phrasing difficult for an average member to understand.
- The signing process rushes members past the document.

WORKED EXAMPLE

IN PRACTICE

A 1,400-member fitness centre with the release buried in paragraph 14 of a 20-paragraph membership agreement.

BEFORE

The release was in 8-point type, mid-agreement, in legal language. Members signed the agreement without seeing it. A member injured on equipment sued; the court found the release inconspicuous and unenforceable.

ACTION

Legal counsel redrafted the release as a separate one-page document: clear heading, 12-point type, plain language listing the real risks of exercise (injury, cardiac event, equipment failure), the member's assumption of those risks, and the release; a separate signature and date line; presented and explained at sign-up before the membership agreement. A copy is given to the member.

AFTER

The Monitor reviewed the redrafted release and 20 membership files with separately signed releases. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Find the release language in your membership agreement.
What page, what size?
2. Separate it into its own one-page document.
3. Have counsel confirm it meets local requirements.
4. Require a separate signature.

The most common mistake: A release the member never saw because it was on page three in small type.

SELF-ASSESSMENT QUESTIONS

1. Is assumption-of-risk and liability release language genuinely conspicuous, not buried within a longer document? — *Real, prominent placement, not language a member could reasonably overlook.*

Evidence: Waiver document format review

2. Is the language genuinely clear and unambiguous, not dense legal phrasing difficult for an average member to understand? — *Real, plain language, not technical drafting that obscures actual meaning.*

Evidence: N/A — tested directly

3. Is the member given genuine, sufficient time to actually read the document before signing, not rushed through it? — *Real, adequate time, not a process that moves the member past the document quickly.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **The waiver is conspicuous in print form but less clearly formatted in the digital sign-up version.** — Genuine conspicuousness needs to hold across whichever format a member actually encounters.
- **Core language is clear but specific activity-related risks are described more vaguely.** — Specific, genuine clarity about actual risks matters as much as clarity about the waiver's general existence.
- **Time is generally sufficient but the process doesn't actively encourage members to actually read, only permits it.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current waiver document and signing process for genuine conspicuousness and clarity.
Week 2	Revise language for genuine plain-language clarity, removing unnecessary legal density.
Week 3	Adjust the signing process to genuinely encourage, not just permit, reading before signing.
Ongoing	Confirm conspicuousness holds across both print and digital sign-up formats.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Format review	Reviews the actual waiver document for genuine conspicuousness and clear placement of key terms.
DOCUMENT	Language clarity review	Reviews language for genuine plain-language clarity, not dense legal phrasing.
OBSERVE	Signing process observation	Observes the actual sign-up process for genuine, sufficient time to review before signing.

SUPERVISOR TIPS

- **Ask to see the actual waiver document as a new member would encounter it, in whatever format is used.** — Direct review reveals genuine conspicuousness, not an assumption based on the document's content alone.

- **Observe an actual sign-up process to see how much genuine time is given before signing.** — Direct observation reveals real practice, not a stated policy about adequate time.

EVIDENCE BASE

[26] In *Leon v. Family Fitness Center (#107), Inc.* (1998) 61 Cal.App.4th 1227, a liability release clause for a health club membership was declared unenforceable specifically because it was not conspicuous, establishing genuine clarity and conspicuousness as a real, legally recognised requirement for assumption-of-risk language.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

6.2 Informed Consent Actively Corrects the Misconception That Exercise Is Inherently Safe

NON-NEGOTIABLE

The informed consent conversation actively, specifically addresses the genuine, real risks of exercise — not relying on a signature alone to convey this, given many people carry a real, documented misconception that exercising in a gym is somehow inherently safe. The conversation explicitly states the member's right to stop, decline, or modify any exercise at any time, for any reason, without needing to justify it.

In plain terms: The consent conversation actually tells the member that exercise carries real risks — injury, cardiac events, aggravation of conditions — rather than treating it as obviously safe.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

People assume exercise is good for them, therefore safe. It is good for them; it is not without risk. Musculoskeletal injury is common; cardiac events during vigorous exercise, though rare, are real and more likely in the sedentary and those with risk factors; existing conditions can worsen with the wrong programme. Informed consent means the member has been told this — in words, not only in a document — and has the chance to ask. A member who was never told exercise could harm them cannot have consented to that risk.

WHAT GOOD LOOKS LIKE

- The consent conversation actively, specifically addresses real exercise risks.
- The gym-is-inherently-safe misconception is specifically, genuinely corrected.
- Members can explain back specific, genuine risks, not just confirm signing.

COMMON FAILURE MODES

- Consent relies on signature alone, without active conversation.
- The misconception that gyms are inherently safe goes unaddressed.
- Members cannot describe any specific risk beyond having signed a document.

WORKED EXAMPLE

IN PRACTICE

A 1,300-member fitness centre where the waiver was signed at reception without discussion.

BEFORE

The release was signed. Nothing was said. Members assumed the waiver was a formality. A member who suffered a cardiac event during a class said he had 'no idea' exercise could do that.

ACTION

A consent conversation was scripted for sign-up: the fitness professional explains the main risks (injury, cardiac events, condition aggravation), why screening matters, what the facility does to reduce risk (screening, supervision, AED), and what the member should do (report symptoms, follow the programme, stop if unwell). The member is invited to ask questions. The

	conversation is recorded as having occurred. It takes five minutes.
AFTER	The Monitor reviewed 20 sign-up records with the consent conversation documented and observed one. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask five recent members whether anyone told them exercise carries risks.
2. Script a five-minute consent conversation.
3. Deliver it at every sign-up.
4. Record that it happened.

The most common mistake: Treating the waiver signature as informed consent — a signature is not a conversation.

SELF-ASSESSMENT QUESTIONS

1. Does the consent conversation actively, specifically address real exercise risks, not rely on a signature alone? — *Real, active conversation, not a document handed over for signature without discussion.*

Evidence: Informed consent conversation record

2. Is the misconception that a gym setting itself makes exercise inherently safe genuinely, specifically addressed? — *Specific, genuine correction of this real misconception, not assumed unnecessary.*

Evidence: N/A — tested directly

3. Can a member explain back genuine, specific risks associated with their activity, not just confirm they signed something? — *Real, demonstrated understanding, not confirmation of signature alone.*

Evidence: N/A — tested directly

4. Is the member's right to stop, decline, or modify any exercise at any time explicitly stated, with instructors able to describe what happens when exercised? — *A genuine, honoured right, not an assumption that paying for a class obligates the member to complete it.*

Evidence: Consent document, instructor interview

COMMON REASONS FOR A PARTIAL ANSWER

- **Conversation happens for personal training clients but less consistently for general membership sign-up.** — Every member, not personal training clients alone, deserves genuine informed consent.
- **General risk is discussed but the specific gym-safety misconception isn't directly named and addressed.** — This specific, documented misconception deserves direct, explicit correction, not general risk discussion alone.
- **The conversation happens but member understanding isn't actively verified afterward.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current sign-up practice for genuine, active risk conversation versus signature alone.
Week 2	Train staff to specifically address the gym-is-inherently-safe misconception.
Week 3	Extend genuine consent conversation to general membership sign-up, not personal training alone.
Ongoing	Spot-check member understanding after consent conversations.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Consent conversation observation	Observes an actual sign-up interaction for genuine, active risk discussion.
ASK	Misconception correction interview	Asks staff whether and how they specifically address the belief that gym exercise is inherently safe.
ASK	Member understanding check	Asks a member to explain back specific risks associated with their activity.

SUPERVISOR TIPS

- **Ask a recent member what specific risks they remember being told about.** — This tests genuine understanding, not just that a document was signed.

- **Ask staff directly whether they address the belief that gyms are inherently safe.** — A specific, confident answer reveals genuine practice addressing this documented misconception.

EVIDENCE BASE

[27] Fitness liability guidance specifically identifies that while most people understand exercise carries some risk, many hold a genuine, documented misconception that exercising within a gym setting is inherently safe, establishing active correction of this belief as necessary to genuine informed consent, distinct from signature alone.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

6.3 **Consent Scope Is Specific to the Actual Activity,
Not Assumed to Cover Everything**

NON-NEGOTIABLE

Consent obtained for one activity or location is not treated as automatically covering a different activity, a different location, or a third-party event — with specific, additional consent genuinely obtained when a member's actual participation extends beyond what the original consent reasonably covered.

In plain terms: Consent for one activity — the gym floor — does not automatically cover others — a climbing wall, a cold plunge, an outdoor bootcamp, a new location — each gets its own.

Facility category	Crisis	Transition	Small	Standard
Applicability	N/A	Full	Adapted	Full

WHY THIS MATTERS

A member who joined for the gym and signed a release for 'use of the facility' did not consent to the risks of the climbing wall added later, the ice bath, the trail run, or the sister site across town with different equipment. Each activity has different risks; each needs consent that

names it. The facility keeps a list of activities requiring specific consent and obtains it before participation. A general release stretched to cover everything covers nothing well.

WHAT GOOD LOOKS LIKE • Additional, specific consent is genuinely obtained for activities beyond original scope. • Specialty activities have their own consent addressing genuinely distinct risks. • Third-party events and off-site activities receive genuine, specific consent reconsideration.	COMMON FAILURE MODES • Original membership consent is assumed to cover any subsequent activity. • Specialty activities rely on generic consent not addressing their distinct risks. • Third-party events are assumed covered by general membership consent.
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WORKED EXAMPLE

IN PRACTICE	
<i>A 1,600-member fitness centre that had added a climbing wall, cold plunge, and outdoor sessions.</i>	
BEFORE	All members used all activities on the original membership release. A member injured on the climbing wall had signed a release that mentioned 'exercise equipment' only. No activity-specific consent existed.
ACTION	A list of activities requiring specific consent was defined: climbing wall, cold plunge, sauna, outdoor sessions, combat classes, any new location. Each has a short activity-specific consent naming its risks, obtained before first participation, recorded in the member's file. Access to those activities is gated by the consent record.
AFTER	The Monitor reviewed the activity list, the specific consents, and 20 member files with activity consents recorded and access matched. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List every activity you offer beyond the gym floor.
2. Write a short specific consent for each.
3. Obtain it before first participation.
4. Gate access on the record.

The most common mistake: One release signed in 2019 covering a climbing wall installed in 2025.

SELF-ASSESSMENT QUESTIONS

1. Is specific, additional consent genuinely obtained when a member's activity extends beyond the original scope? — *Real, additional consent for genuinely different activities, not an assumption original consent covers everything.*

Evidence: Activity-specific consent record

2. Does consent for a specialty class or higher-risk activity specifically address that activity's distinct risks? — *Specific, genuine risk disclosure for the actual activity, not generic fitness consent applied broadly.*

Evidence: Specialty activity consent documentation

3. Is consent scope genuinely reconsidered for a third-party event or off-site activity, not assumed covered by general membership consent? — *Real, specific reconsideration, not an assumption of automatic coverage.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Specific consent is obtained for major specialty classes but not consistently for shorter-term or trial activities.** — Every genuinely distinct activity deserves specific consent, not only ongoing, major offerings.
- **Consent scope is reconsidered for off-site events but not consistently for third-party instructors using the facility.** — A third-party instructor's activity may carry genuinely different risk than the facility's own standard offerings.
- **Additional consent is technically obtained but doesn't specifically explain how this activity's risks differ from general membership.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current consent scope practice for genuine activity-specific coverage.
Week 2	Establish specific consent processes for specialty activities and third-party events.
Week 3	Ensure specific consent genuinely addresses what makes each activity's risks distinct.
Ongoing	Audit consent scope for new or evolving activity offerings.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Scope-specific consent review	Reviews whether additional consent is genuinely obtained for activities beyond original scope.
DOCUMENT	Specialty activity consent review	Reviews whether specialty or higher-risk activities have their own specific consent addressing distinct risks.
ASK	Third-party event interview	Asks staff how consent is handled for a third-party event or off-site activity.

SUPERVISOR TIPS

- **Ask how consent is handled for a specific specialty class with genuinely distinct risk.** — A specific, real example reveals whether scope is genuinely reconsidered, not assumed covered.
- **Ask about consent for a third-party instructor or event using the facility.** — This reveals whether scope-specific practice extends beyond the facility's own standard offerings.

EVIDENCE BASE

[28] Liability waivers are established as interpreted narrowly, with consent signed at one location or for one activity not extending to a different location, third-party events, or activities outside what the participant reasonably understood they were consenting to.

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Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

6.4

Minor Participation Follows the Legally Sound Consent Construction

NON-NEGOTIABLE

Consent for a minor's participation follows the legally sound construction — a parent or guardian assuming risk and releasing their own claims — not the weaker, less reliable construction of a parent purporting to waive the minor's own future claims on the minor's behalf.

In plain terms: For a member under 18, a parent or guardian assumes the risk on the child's behalf and signs — using the form of consent that is legally valid for minors in this jurisdiction.

Facility category	Crisis	Transition	Small	Standard
Applicability	N/A	Full	Adapted	Full

WHY THIS MATTERS

A minor cannot sign a binding release. A parent's signature is required — and in many jurisdictions, a parent cannot waive a child's right to sue for negligence, though they can assume risk and consent to participation. The legally sound construction varies by jurisdiction and must be obtained from counsel: typically the parent's assumption of risk and consent, an acknowledgement of the child's participation, and emergency contact and medical information. A facility that uses its adult waiver for minors, or lets a 16-year-old sign for themselves, has no valid consent.

WHAT GOOD LOOKS LIKE

- Minor consent genuinely uses the stronger, legally sound construction.
- Parent or guardian signature is genuinely obtained for every minor.
- Minor consent documentation has been

COMMON FAILURE MODES

- Documentation attempts to have a parent waive the minor's own future claims.
- Minors participate without genuine parent or guardian signature.
- Minor consent language is simply adapted from adult

specifically, legally reviewed.

waivers without specific legal review.

WORKED EXAMPLE

IN PRACTICE

A 1,400-member fitness centre admitting members from age 14.

BEFORE	Minors signed the adult release themselves or a parent signed the adult form. No minor-specific consent. No emergency medical information for minors. Counsel advised that none of it was valid.
ACTION	A minor participation consent was drafted with counsel: parent or guardian identity verified; parent's assumption of risk and consent to participation; acknowledgement of supervision arrangements; emergency contact and medical information; annual renewal. Minors cannot join without it. Reception was trained on the requirement.
AFTER	The Monitor reviewed the consent form and 15 minor member files with parent-signed consents and emergency information. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Find every member under 18. Who signed their consent?
2. Ask counsel for the valid construction in your jurisdiction.
3. Draft a minor consent with emergency medical information.
4. Re-obtain consent for every existing minor.

The most common mistake: Letting a 17-year-old sign the adult waiver.

SELF-ASSESSMENT QUESTIONS

1. Does minor consent documentation genuinely use the stronger construction — parent assumes risk and releases their own claims?
— *The specific, legally sound construction, not the weaker attempt to*

waive the minor's own future claims.

Evidence: Minor consent documentation

2. Is a parent or guardian's signature genuinely obtained for every minor's participation, not assumed unnecessary? — *Real, obtained signature, not an assumption of implied consent.*

Evidence: N/A — tested directly

3. Is minor consent documentation genuinely reviewed for legal soundness, not simply adapted from adult consent language? — *Real, specific review for minor-appropriate construction, not adult language applied without adaptation.*

Evidence: Legal review documentation

COMMON REASONS FOR A PARTIAL ANSWER

- **The stronger construction is used for new minor sign-ups but older documentation hasn't been updated.** — Every current minor participant deserves the protection of the legally sound construction, not only new sign-ups.
- **Signature is obtained but the document doesn't specifically distinguish parent's own claims from the minor's.** — Genuine legal soundness depends on this specific distinction being clearly, deliberately made.
- **Documentation is reasonable but hasn't been reviewed by a licensed attorney familiar with the relevant jurisdiction.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current minor consent documentation for the specific, legally sound construction.
Week 2	Revise documentation to clearly distinguish parent's own claims from the minor's.
Week 3	Obtain specific legal review of minor consent language.
Ongoing	Update documentation for existing minor participants to the sound construction.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Construction review	Reviews minor consent documentation for genuine use of the legally sound construction.
DOCUMENT	Signature verification	Verifies parent or guardian signature is genuinely obtained for every minor participant.
DOCUMENT	Legal review documentation check	Reviews whether minor consent language has been specifically, legally reviewed.

SUPERVISOR TIPS

- **Ask to see the actual minor consent document and check for the specific, sound construction.** — A specific, real document reveals whether the legally sound approach is genuinely used.
- **Ask when minor consent language was last reviewed by a qualified attorney.** — A specific, real answer reveals genuine legal diligence, not general confidence in adequacy.

EVIDENCE BASE

[29] The legally stronger construction for minor participation consent has the parent or guardian assume risk on the child's behalf and release the parent's own claims, distinct from a parent purporting to waive the minor's own future claims, which holds up far less reliably.

[ASF training courses on GMJ Academy](#) →

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Members Can Genuinely Access and 6.5 Review Their Own Signed Consent Documents

CORE

A member can genuinely obtain a copy of their own signed consent and waiver documents on request — not told the facility doesn't provide copies, or made to navigate a

difficult, unclear process to access what they themselves agreed to.

In plain terms: A member can ask for a copy of what they signed and get it — not be told it is 'on file' or 'not available.'

Facility category	Crisis	Transition	Small	Standard
Applicability	N/A	Full	Adapted	Full

WHY THIS MATTERS

A member who wants to know what they agreed to has the right to see it. Refusing, delaying, or claiming the document cannot be found suggests the facility has something to hide — and if a dispute arises, the facility's own inability to produce the signed document undermines it. Every consent and waiver is retained, retrievable by member, and provided on request within days. The member is told at sign-up that they can have a copy.

WHAT GOOD LOOKS LIKE

- Members can genuinely obtain copies of their own signed documents on request.
- The process is genuinely clear and known to members.
- Requests are fulfilled within a genuinely reasonable timeframe.

COMMON FAILURE MODES

- Members are told copies aren't provided or face a difficult process.
- Members don't know how to request their own documents.
- Requests go unanswered or are significantly delayed.

WORKED EXAMPLE

IN PRACTICE

A 1,200-member fitness centre with paper consents in boxes.

BEFORE

Consents were filed in date order in boxes. Finding a specific member's took hours. Members who asked were told 'it's on file.' One was refused. When a dispute arose, the facility could not find the member's signed release.

ACTION	All consents were scanned and indexed by member in the membership system. New consents are captured digitally at sign-up. Any member can request a copy at reception or through the app and receives it within three working days. Sign-up includes the statement that copies are available.
AFTER	The Monitor requested three members' consents at reception and received them within minutes. Reviewed the retention system. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Try to find a specific member's signed consent from two years ago. How long does it take?
2. Scan and index all consents by member.
3. Capture new ones digitally.
4. Tell members they can have a copy.

The most common mistake: Consents in boxes that nobody can find when it matters.

SELF-ASSESSMENT QUESTIONS

1. Can a member genuinely obtain a copy of their own signed consent documents on request? — *Real, genuine access, not a difficult or discouraged process.*

Evidence: Document access process documentation

2. Is this process genuinely clear and known to members, not something they'd struggle to discover? — *Real, communicated awareness of how to request documents, not an obscure or undisclosed process.*

Evidence: N/A — tested directly

3. Is a request fulfilled within a genuinely reasonable timeframe, not delayed indefinitely? — *Real, prompt fulfillment, not a request that goes unanswered or significantly delayed.*

Evidence: Request fulfillment record

COMMON REASONS FOR A PARTIAL ANSWER

- **A process exists but isn't proactively communicated to members at the time of signing.** — A process members don't know about provides limited real access when they actually need it.
- **Requests are fulfilled but the timeframe isn't consistent, sometimes taking notably longer.** — A genuinely reasonable, consistent timeframe is what makes access reliably meaningful.
- **Digital records are easily accessible but older, physical signatures are harder to retrieve.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current document access process for genuine member accessibility.
Week 2	Establish and communicate a clear, known process for requesting signed documents.
Week 3	Confirm consistent, reasonable fulfillment timeframes across digital and physical records.
Ongoing	Track document request fulfillment for continued reliability.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Access process review	Reviews the actual process for members to obtain copies of their own consent documents.
ASK	Member awareness interview	Asks a member whether they know how to request a copy of their signed documents.
DOCUMENT	Fulfillment timeframe review	Reviews records for genuine, prompt fulfillment of document requests.

SUPERVISOR TIPS

- **Ask a member directly whether they know how to get a copy of their own signed waiver.** — A confident, specific answer reveals genuine, known access, not an assumed process.
- **Request a copy of a specific document as a real test of the process.** — A real test reveals genuine practice, not a stated policy about member access.

EVIDENCE BASE

[30] Genuine member access to their own signed consent documentation is established as consistent with the underlying purpose of informed consent, supporting transparency and a member's ongoing understanding of what they agreed to.

[ASF training courses on GMJ Academy →](#)

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← **Fitness & Wellness
Standards — all standards**

**Self-assess against these
criteria →**

← **Standard 5 — Program
Design & Individualization**

**Standard 7 — Governance &
Staffing →**

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Standard 7 — Governance & Staffing

6 criteria · 3 non-negotiable · 3 core · Version 3.1

CRITERIA IN THIS STANDARD

- 7.1 — Every Incident Is Documented With Genuine, Specific Detail
- 7.2 — Incident Notification Meets Insurance-Required Timeframes
- 7.3 — The Facility Carries Both General and Professional Liability Insurance
- 7.4 — Incident Patterns Are Actively Reviewed for Genuine Prevention
- 7.5 — Staff, However Few, Receive Genuine Training Beyond Instructor Certification Alone
- 7.6 — Member and Customer Feedback Has an Independent Channel, Not Just an Internal One

7.1 Every Incident Is Documented With Genuine, Specific Detail

NON-NEGOTIABLE

Every incident — injury, equipment failure, near-miss — is documented with genuine, specific detail: precise location, objective factual description, injury details, response actions, and relevant environmental factors — not a vague summary that fails to actually capture what happened.

In plain terms: Every incident — injury, equipment failure, near-miss — is written up with real detail: exactly where, exactly when, what happened, who saw it, what was done.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

'Member fell, first aid given' tells no one anything. An incident report that says 'Treadmill 7, 18:42, member's foot caught on stationary belt while stepping on at 12 km/h setting; witnessed by instructor J; grazed knee; first aid; member declined ambulance; treadmill checked, no fault; member had not attached safety clip' allows analysis, prevention, and defence. Detail means: location, time, activity, equipment, mechanism, injury, witnesses, response, member's account, follow-up. A structured form with mandatory fields produces it.

WHAT GOOD LOOKS LIKE

- Incident reports genuinely include precise location detail.
- Descriptions are genuinely objective and factual, not vague summaries.
- Reports genuinely capture response actions and environmental factors.

COMMON FAILURE MODES

- Location is described vaguely, not specifically.
- Descriptions are imprecise summaries or unsupported conclusions.
- Reports don't capture response actions or environmental context.

WORKED EXAMPLE

IN PRACTICE

A 1,500-member fitness centre with a one-line incident book.

BEFORE

Incidents were logged as a line: date, name, 'injury.' No detail. When an injured member's lawyer requested the incident report, the facility could produce a single line. Patterns were invisible.

ACTION

A structured incident form was introduced with mandatory fields: date/time, exact location, equipment (with ID), activity, mechanism, injury,

witnesses and their accounts, response and first aid, member statement, follow-up actions, reported by. Completed within two hours of any incident. Reviewed by the manager within 24 hours. Stored securely.

AFTER

The Monitor reviewed 30 incident reports with complete structured detail. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Read your last ten incident reports. Could you reconstruct what happened from each?
2. Build a structured form with mandatory fields.
3. Require completion within two hours.
4. Review every report within 24 hours.

The most common mistake: 'Injury — first aid given' — the report that will not help anyone.

SELF-ASSESSMENT QUESTIONS

1. Does incident documentation genuinely include precise location, not a vague general area? — *Real, specific location detail, not a general description like "the gym."*

Evidence: Incident report format review

2. Is the description genuinely objective and factual, not a vague summary or a conclusion instead of facts? — *Real, factual detail, not an imprecise summary or unsupported conclusion.*

Evidence: N/A — tested directly

3. Does documentation genuinely capture response actions and relevant environmental factors, not just that an incident occurred? — *Complete, specific detail across all genuinely relevant categories, not a partial record.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Location and description are specific but response actions taken aren't consistently documented.** — Response detail matters as much for genuine investigation and improvement as the incident description itself.

- **Reports are thorough for injuries but less detailed for near-misses and equipment issues.** — Near-misses and equipment issues carry real, genuine value for prevention, deserving the same documentation discipline.
- **Documentation is generally specific but environmental factors, like flooring or lighting, are inconsistently noted.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current incident report template and completed reports for genuine specificity.
Week 2	Revise the report template to require precise location, objective description, and environmental factors.
Week 3	Train staff on completing genuinely specific, factual incident documentation.
Ongoing	Audit incident reports periodically for continued genuine specificity.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Report format review	Reviews the actual incident report template and completed reports for genuine, specific detail.
DOCUMENT	Sample report review	Reviews a sample of real, completed incident reports for objective, factual, specific content.
ASK	Staff documentation interview	Asks staff to describe what specific detail they'd include in a real incident report.

SUPERVISOR TIPS

- **Ask to see a real, recent incident report and assess its actual specificity.** — A real, specific example reveals genuine practice, not an assumption of adequate documentation.
- **Ask staff to describe how they'd document a specific, hypothetical incident.** — A specific, detailed answer reveals genuine understanding of what real documentation requires.

EVIDENCE BASE

[31] Effective incident reporting requires specific, objective detail — precise location, factual description of the event, injury details, response actions taken, and environmental factors — with vague documentation identified as a leading factor in denied insurance claims and failed liability defence.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

7.2 Incident Notification Meets Insurance-Required Timeframes

NON-NEGOTIABLE

A significant incident is reported to the facility's insurance carrier within the genuinely required timeframe — not delayed until it's convenient, or handled informally without meeting the specific notification window insurance coverage actually depends on.

In plain terms: Significant incidents are reported to the insurer within the time the policy requires — and someone knows what that time is.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Insurance policies require notification of incidents that could lead to a claim within a defined period — often days. Late notification can void coverage for that incident. The facility must know the notification requirement for each policy, have a definition of 'significant incident' that triggers it, assign someone to notify, and record that it was done. A serious injury reported to the insurer three months later, when the lawyer's letter arrives, may be an uninsured injury.

WHAT GOOD LOOKS LIKE

- The facility has specific, documented knowledge of

COMMON FAILURE MODES

- The facility doesn't specifically know its

its insurer's required timeframe.

- Significant incidents are genuinely reported within this timeframe.
- A defined process ensures notification even outside normal hours.

insurer's notification requirement.

- Notification is delayed beyond the required timeframe.
- No process ensures notification outside normal business hours.

WORKED EXAMPLE

IN PRACTICE

A 1,300-member fitness centre that notified insurers when a claim arrived.

BEFORE

Nobody knew the notification requirement. A serious injury was not reported until a claim was made four months later; the insurer reserved its position on late notification. The facility faced the possibility of an uninsured claim.

ACTION

The insurance policies were reviewed; notification requirements were extracted (7 days for injuries requiring medical treatment). A 'significant incident' definition was written. The general manager is responsible for notification within the period, with the notification recorded on the incident report. A monthly reconciliation checks that every significant incident was notified.

AFTER

The Monitor reviewed the notification requirements, the definition, and 8 significant incidents in six months all with notification recorded within the period. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Read your insurance policies. What is the notification period?
2. Define 'significant incident.'
3. Assign notification to a named person.
4. Record notification on the incident report.

The most common mistake: Notifying the insurer when the claim arrives — that may be too late.

SELF-ASSESSMENT QUESTIONS

1. Does the facility know its specific insurance carrier's required notification timeframe? — *Real, specific knowledge of the actual requirement, not a general assumption of adequate timing.*

Evidence: Insurance notification requirement documentation

2. Is a significant incident genuinely reported within this required timeframe, not delayed? — *Real, timely reporting matching the actual requirement, not informal or delayed notification.*

Evidence: Notification timing record

3. Is there a specific, defined process ensuring notification happens even outside normal business hours? — *A real, defined process covering any time an incident might occur, not limited to convenient hours.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Notification timing is reliable during business hours but less consistent for incidents occurring after closing.** — A significant incident deserves the same timely notification regardless of when it occurs.
- **The general requirement is known but the specific number of hours isn't precisely documented.** — Precise knowledge of the actual requirement is what makes genuine, reliable compliance possible.
- **Notification happens but isn't consistently confirmed as received by the insurer.**

IMPLEMENTATION PLAN

When	What
Week 1	Confirm the facility's specific insurance notification timeframe requirement.
Week 2	Establish a clear, documented process for timely notification, including after hours.
Week 3	Train staff on the specific requirement and notification process.

When	What
Ongoing	Confirm notification receipt for significant incidents.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Requirement knowledge review	Reviews whether the facility has specific, documented knowledge of its insurer's notification timeframe.
DOCUMENT	Timing record review	Reviews records for a sample of significant incidents to confirm genuine, timely notification.
DOCUMENT	After-hours process review	Reviews the defined process for notification outside normal business hours.

SUPERVISOR TIPS

- **Ask staff to state the facility's specific insurance notification timeframe.** — A specific, confident answer reveals genuine knowledge, not an assumption of general adequacy.
- **Ask how notification would happen for an incident occurring after normal closing hours.** — A specific, confident answer reveals a genuine, defined process.

EVIDENCE BASE

[32] Many insurance carriers require incident notification within 24 to 48 hours of a significant event, with insufficient or delayed documentation identified as a leading factor in denied insurance claims.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

7.3 The Facility Carries Both General and Professional Liability Insurance

NON-NEGOTIABLE

The facility genuinely carries both general liability insurance, covering physical incidents like slips and equipment injuries, and professional liability insurance, covering claims arising from actual instruction and program design — not general liability alone, leaving claims about instructor competence or program safety genuinely uncovered.

In plain terms: The facility carries both general liability insurance (slips, equipment) and professional liability insurance (bad advice, bad programming) — with certificates on file.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

General liability covers the member who slips on a wet floor or is hurt by a failed machine. Professional liability covers the member injured because a trainer's programme was wrong, or advice was outside scope. They are different policies covering different harms. A facility with only general liability is uninsured for its instructors' professional errors — which are common. Both policies, current, with adequate limits, certificates on file, and reviewed annually.

WHAT GOOD LOOKS LIKE

- The facility genuinely carries both general and professional liability insurance.
- Professional liability coverage genuinely matches actual scope of instruction and programming.
- Coverage is genuinely current and active.

COMMON FAILURE MODES

- Only general liability is carried, leaving instruction-related claims uncovered.
- Professional liability coverage is minimal or mismatched to actual operations.
- Coverage has lapsed or is allowed to expire without renewal.

WORKED EXAMPLE

IN PRACTICE

A 1,400-member fitness centre with general liability only.

BEFORE	The facility had general liability insurance. It assumed this covered everything. A member injured following a trainer's inappropriate programme sued; the general liability insurer declined as the claim was professional.
ACTION	Professional liability insurance was obtained covering all instructors' activities within scope. Both policies are reviewed annually with the broker for adequacy of limits. Certificates are on file. Instructors who also work independently are required to hold their own professional cover.
AFTER	The Monitor reviewed both current certificates and the annual review record. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Find your insurance certificates. Is there a professional liability policy?
2. If not, obtain one.
3. Review limits annually with a broker.
4. Keep certificates on file.

The most common mistake: Assuming general liability covers a trainer's bad programme — it does not.

SELF-ASSESSMENT QUESTIONS

1. Does the facility genuinely carry both general liability and professional liability insurance? — *Real, active coverage of both distinct types, not general liability alone.*
Evidence: Insurance policy documentation
2. Is professional liability coverage genuinely adequate to the facility's actual scope of instruction and programming? — *Real, appropriate coverage level matched to actual operations, not a minimal*

or mismatched policy.

Evidence: N/A — tested directly

3. Is coverage genuinely current, not lapsed or allowed to expire without renewal? — *Real, active, current coverage, not a policy that has quietly lapsed.*

Evidence: Coverage currency verification

COMMON REASONS FOR A PARTIAL ANSWER

- **Both coverage types exist but professional liability limits are lower than the facility's actual specialty program offerings would warrant.** — Coverage adequacy should genuinely reflect the facility's real scope, including higher-risk specialty programming.
- **Coverage is current but hasn't been reviewed against the facility's actual, current operations in some time.** — A facility's operations can genuinely change, and coverage should be periodically reconfirmed as adequate.
- **General liability is comprehensive but professional liability was only recently added, leaving a historical gap.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current insurance coverage for both general and professional liability.
Week 2	Confirm professional liability coverage genuinely matches the facility's actual scope of operations.
Week 3	Verify coverage currency and address any lapse.
Ongoing	Periodically review coverage adequacy as facility operations evolve.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Policy documentation review	Reviews actual insurance policy documentation for genuine coverage of both types.
DOCUMENT	Coverage adequacy review	Reviews whether professional liability coverage genuinely matches the facility's actual scope of operations.

Method	What	Detail
DOCUMENT	Currency verification	Verifies coverage is genuinely current, not lapsed.

SUPERVISOR TIPS

- **Ask to see the actual, current insurance policy documents for both coverage types.** — Real, specific documents reveal genuine coverage, not an assumption of adequate protection.
- **Ask whether professional liability coverage was reviewed when a new specialty program was added.** — A specific, real answer reveals whether coverage genuinely tracks the facility's actual, evolving operations.

EVIDENCE BASE

[33] Fitness facility insurance guidance distinguishes general liability coverage, addressing physical incidents such as slip-and-fall accidents and equipment injuries, from professional liability coverage, addressing claims arising from training errors, program design, or inadequate instruction, with most facilities requiring both.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

7.4 Incident Patterns Are Actively Reviewed for Genuine Prevention CORE

Incident reports are genuinely, actively reviewed for patterns — a specific piece of equipment, a specific area, a specific time — with real, resulting preventive action, not filed individually without ever being analyzed collectively for what they might reveal.

In plain terms: Incident reports are reviewed together for patterns — the same machine, the same area, the same class, the same time — and the pattern is fixed.

Facility category	Crisis	Transition	Small	Standard
Applicability	N/A	Full	Adapted	Full

WHY THIS MATTERS

One fall on treadmill 7 is an incident. Three in a quarter is a pattern that says something about treadmill 7, its position, or its users. Five injuries in the same class say something about the instructor or the programme. Pattern review — a monthly look at all incidents by equipment, location, activity, time, and instructor — finds the cause behind the incidents. Then it is fixed: the machine repositioned, the class redesigned, the floor resurfaced. Incident-by-incident review never sees it.

WHAT GOOD LOOKS LIKE

- Incident reports are genuinely, actively reviewed collectively for patterns.
- Pattern review leads to real, resulting preventive action.
- Review happens on a genuine, regular schedule, not only reactively.

COMMON FAILURE MODES

- Reports are filed individually, never reviewed collectively for patterns.
- Patterns identified don't lead to any resulting preventive action.
- Review only happens reactively after a serious event.

WORKED EXAMPLE

IN PRACTICE

A 1,500-member fitness centre that reviewed incidents individually.

BEFORE

Each incident was reviewed and closed. Nobody looked across them. When the Coordinator tabulated a year: 40% of injuries were in one class type; 25% involved one row of cable machines with inadequate clearance. Neither had been noticed.

ACTION

A monthly incident pattern review was introduced: all incidents tabulated by equipment, location, activity, time, instructor, and injury type; any cluster investigated; actions recorded. The high-injury class was redesigned with the instructor; the cable row was reconfigured. Patterns and actions are reported to the owner quarterly.

AFTER

The Monitor reviewed six monthly pattern reviews with two clusters identified and actioned, and the following quarter's incident rate (down 35%).
Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Tabulate last year's incidents by equipment, area, and activity.
2. Look for clusters.
3. Investigate and fix the biggest one.
4. Repeat monthly.

The most common mistake: Closing each incident individually and never seeing that they are all on the same machine.

SELF-ASSESSMENT QUESTIONS

1. Are incident reports genuinely, actively reviewed collectively for patterns, not only individually? — *Real, collective pattern analysis, not reports filed and reviewed only one at a time.*

Evidence: Pattern review record

2. Does genuine pattern review lead to real, resulting preventive action? — *Actual, resulting change, not pattern identification without any consequence.*

Evidence: Preventive action record

3. Is pattern review conducted on a genuine, regular schedule, not only occasionally or after a serious event? — *Real, scheduled, ongoing review, not reactive analysis only after something serious occurs.*

Evidence: Review schedule documentation

COMMON REASONS FOR A PARTIAL ANSWER

- **Review happens but isn't documented in a way that makes the pattern-identification process genuinely traceable.** — Documented review reveals genuine practice more reliably than an assumption that patterns are informally noticed.
- **Patterns are identified but resulting action addresses only the most severe findings.** — Genuine prevention benefits from addressing patterns across the full range of severity, not only the most serious.

- **Review happens on schedule for injury reports but near-miss and equipment-issue reports are analyzed less consistently.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current incident review practice for genuine, collective pattern analysis.
Week 2	Establish a regular, scheduled process for reviewing incident reports collectively.
Week 3	Build a process connecting identified patterns to genuine, resulting preventive action.
Ongoing	Conduct pattern review on the established schedule, including near-misses and equipment issues.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Pattern review record review	Reviews evidence of genuine, collective analysis of incident reports for patterns.
DOCUMENT	Preventive action review	Reviews whether pattern review results in genuine, resulting preventive action.
DOCUMENT	Review schedule review	Reviews whether pattern review happens on a real, regular schedule.

SUPERVISOR TIPS

- **Ask for a real, specific example of a pattern identified through incident review and what changed as a result.** — A real, traceable example reveals genuine practice, not documentation without analysis.
- **Ask how often incident reports are genuinely reviewed collectively, not individually as they occur.** — A specific, confident answer reveals a genuine, scheduled process.

EVIDENCE BASE

[34] Consistent incident reporting is established as valuable specifically for identifying equipment maintenance needs, high-risk areas, and training gaps through pattern analysis, distinct from individual incident documentation reviewed only in isolation.

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

7.5 **Staff, However Few, Receive Genuine Training Beyond Instructor Certification Alone** CORE

Every staff member, including those in administrative, reception, or support roles — not only certified instructors — receives genuine, documented training relevant to their actual role and safety responsibilities, not left to informal, on-the-job learning alone. The facility has a named person with documented accountability for safety and quality, a separate named accountability for financial decisions, and a brief, genuine statement of mission, values, and expected staff conduct. Every policy and procedure in use is authorised by a named person and reviewed on a defined schedule.

In plain terms: Every staff member — reception, sales, cleaning, not only instructors — has training for their actual role: emergencies, safety, member interaction, data protection.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Adapted	Full

WHY THIS MATTERS

The receptionist handles medical screening forms, the first response to a collapse at the front desk, member complaints, and personal data. The cleaner handles chemicals and the changing rooms. The salesperson explains the waiver. Each needs training for that, not just instructors for exercise. Training is documented per person: emergency response (3.3), safety awareness, member communication, data protection, role-specific tasks. A facility that trains only instructors has untrained people at every other point of member contact.

WHAT GOOD LOOKS LIKE

- Every staff member, including administrative and support roles, receives genuine, documented training.
- Training genuinely covers role-specific safety responsibilities.
- Training is genuinely refreshed periodically, not a one-time event.

COMMON FAILURE MODES

- Training is limited to certified instructors, leaving other staff informally trained.
- Training is generic, not addressing role-specific safety responsibilities.
- Training happens once and is never revisited.

WORKED EXAMPLE

IN PRACTICE

A 1,300-member fitness centre where non-instructor staff received a one-hour induction.

BEFORE

Reception, sales, and cleaning staff had a general induction. No CPR/AED, no safety awareness, no data protection, no complaints handling. A receptionist mishandled a member's medical information; a cleaner mixed chemicals unsafely.

ACTION

A role-based training matrix was built: for each role, the required training (CPR/AED for all; safety awareness for all; data protection for all who handle member information; chemical safety for cleaning; complaints handling for reception and sales; equipment awareness for floor staff). Each staff member has a training file with completion and refresh dates. New staff complete role training in their first month.

AFTER

The Monitor reviewed the matrix and 20 staff training files across roles, all complete. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List every role and what each person actually does.

2. For each, write the training needed.
3. Check every staff member's file against it.
4. Fill the gaps this quarter.

The most common mistake: Training instructors and treating everyone else as 'just admin.'

SELF-ASSESSMENT QUESTIONS

1. Does every staff member, not only certified instructors, receive genuine, documented training for their actual role? — *Real, structured training extending to administrative and support roles, not instructors alone.*

Evidence: Staff training record

2. Does this training genuinely cover relevant safety responsibilities specific to each role? — *Specific, role-relevant safety content, not generic orientation alone.*

Evidence: N/A — tested directly

3. Is training genuinely refreshed periodically, not completed once and never revisited? — *Real, ongoing training, not a single initial session treated as sufficient indefinitely.*

Evidence: Ongoing training schedule

4. Is there a named person with documented accountability for safety and quality, and a separate named accountability for financial decisions? — *Real, named accountability for each, even at a small facility, not an informal assumption that the owner handles everything.*

Evidence: Governance role documentation

5. Does the facility have a brief, genuine written statement of its mission, values, and expected staff conduct? — *A real, if brief, statement specific to this facility, not a generic poster that could apply to any gym.*

Evidence: Mission/values statement

6. Is every policy and procedure authorised by a named person and reviewed on a defined schedule? — *A real, if lightweight, authorisation and review process, not absent entirely.*

Evidence: Document authorisation/review record

COMMON REASONS FOR A PARTIAL ANSWER

- **Front-desk staff receive general orientation but not specific training on safety-relevant responsibilities like incident reporting.** — Every staff role that genuinely touches safety responsibilities deserves specific, not just general, training.
- **Training is thorough at hire but refresher training lapses for non-instructor roles.** — Every staff member's readiness deserves the same genuine, ongoing reinforcement, not only instructors'.
- **Training covers most safety topics but incident reporting specifics are addressed less thoroughly.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current staff training for genuine coverage beyond certified instructors alone.
Week 2	Build role-specific safety training for administrative and support staff.
Week 3	Establish a consistent refresher schedule across all staff roles.
Ongoing	Confirm training currency across all roles, not instructors alone.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Broad training record review	Reviews training records for administrative and support staff, not only certified instructors.
DOCUMENT	Role-relevance review	Reviews whether training genuinely covers safety responsibilities specific to each role.
DOCUMENT	Ongoing training review	Reviews whether training is genuinely refreshed periodically.

SUPERVISOR TIPS

- **Ask an administrative or front-desk staff member about their own specific safety training.** — This reveals whether genuine training extends beyond certified instructors, not an assumption it does.
- **Ask when training was last refreshed for a non-instructor staff role.** — A specific, real answer reveals genuine, ongoing practice,

not a one-time initial session.

EVIDENCE BASE

[35] Under-educated fitness staff are specifically identified as a documented cause of serious gym accidents, with death identified as a possible outcome, establishing genuine, structured staff training as a real safety requirement extending beyond certified instructors alone.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

7.6

Member and Customer Feedback Has an Independent Channel, Not Just an Internal One

CORE

Members and customers have a genuine, independent channel to raise concerns, praise, and ideas — one that reaches a body outside the facility’s own management, not only an internal suggestion box or feedback form the facility itself reviews and answers.

In plain terms: Members can tell someone who isn’t the club itself when something’s wrong, or right — not just fill in a form the club reads and files away.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Adapted	Full

WHY THIS MATTERS

A member who’s unhappy with a facility they still need — a membership they’ve paid for, a trainer they still see weekly — rarely says so honestly on the facility’s own form. The polite answer goes in the box; the real story goes to a review site or social media instead, later and angrier, after the facility has lost the chance to fix it quietly. An independent channel, reaching a body with no stake in the outcome, is structurally more likely to surface a real problem while it’s still small. ASF’s Customer Voice service provides exactly this: a QR code, a

neutral intermediary, and, for facilities that want it, a real customer council that meets regularly and reviews what members are actually saying.

WHAT GOOD LOOKS LIKE • An independent channel exists, genuinely reaching a body outside the facility's own management. • Concerns raised through it are genuinely acknowledged and answered, not left unaddressed. • Patterns in what members raise genuinely inform real changes at the facility.	COMMON FAILURE MODES • The only feedback channel is an internal form the facility itself reviews and answers. • An independent channel exists on paper but nothing reaches the facility from it in practice. • Feedback is collected but never closes the loop with the person who raised it.
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WORKED EXAMPLE

IN PRACTICE	
<i>An 11-staff fitness club whose only feedback mechanism was a paper suggestion box at reception.</i>	
BEFORE	The suggestion box was checked irregularly. Members who raised a real concern rarely heard back. A locker-room cleanliness issue went unreported for months because no one wanted to complain to the staff who'd see the complaint.
ACTION	A QR code was placed at reception and in the changing rooms, linking to ASF's Customer Voice channel. Feedback now goes directly to ASF, not through the club first. ASF acknowledges within two working days and closes every case in writing.

AFTER

In the first quarter, three members used the channel; one flagged the same locker-room issue, and it was fixed within a week — instead of going unreported for months. The Monitor reviewed the case log. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Read the [Customer Voice](#) page to see the full mechanism.
2. Place the QR code at reception and in any area members spend time unsupervised, such as changing rooms.
3. Tell staff the channel exists and that it doesn't come back through them first.
4. Check in three months whether anything has actually come through it.

The most common mistake: Treating an internal suggestion box the staff themselves check as equivalent to an independent channel.

SELF-ASSESSMENT QUESTIONS

1. Do members have a channel that reaches a body genuinely independent of the facility's own management? — *A real external channel, not an internal form the facility reviews itself.*
Evidence: Feedback channel documentation
2. Are concerns raised through it genuinely acknowledged and answered, not left to sit? — *Real, timely responses, not silence after submission.*
Evidence: Case log or response record
3. Do patterns in what members raise genuinely inform real changes at the facility? — *Evidence of at least one real change traceable to member feedback.*
Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **A feedback channel exists but members aren't told it's independent of the club.** — If members don't know it reaches someone other than the club, it won't be used honestly.

- **Feedback is collected but responses are inconsistent or slow.**
— A channel that doesn't close the loop trains members to stop using it.
- **The channel is new and hasn't yet generated evidence of a real change resulting from it.**

IMPLEMENTATION PLAN

When	What
Week 1	Set up the Customer Voice QR code and review how it works.
Week 2	Place it at reception and in unsupervised member areas.
Week 3	Tell staff it exists and that it bypasses them by design.
Ongoing	Review what comes through it and confirm at least one real change traceable to it each year.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Channel review	Confirms an independent channel exists and is visibly accessible to members.
DOCUMENT	Response record review	Reviews whether concerns raised are genuinely acknowledged and answered.
INTERVIEW	Member awareness check	Asks members directly whether they know the channel exists and that it's independent.

SUPERVISOR TIPS

- **Ask a member, not staff, whether they know how to reach someone outside the club with a concern.** — This reveals whether the channel is genuinely known, not just technically present.
- **Ask to see one real case that came through the channel and what changed because of it.** — A specific, real example reveals genuine use, not a channel that exists only on paper.

EVIDENCE BASE

Independent, external feedback channels are structurally more likely to surface an honest concern than a channel reviewed by the same

organisation being reported on — the same reasoning that underlies independent ombuds practice in other sectors.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

← **Fitness & Wellness
Standards — all standards**

**Self-assess against these
criteria →**

← **Standard 6 — Member
Rights & Informed Consent**

**Standard 8 — Medical
Tourism →**

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ASF STANDARDS · FITNESS & WELLNESS · STANDARD 8

Standard 8 — Medical Tourism

10 criteria · 9 non-negotiable · 1 core · Version 3.0

CRITERIA IN THIS STANDARD

- 8.1 — Pricing Transparency for International Wellness Guests
- 8.2 — Language Access for International Guests
- 8.3 — Booking Agent and Facilitator Verification
- 8.4 — International Guest Complaint and Redress Process
- 8.5 — Travel Fatigue Is Factored Into Program Intensity, Not Ignored
- 8.6 — Extreme or High-Intensity Wellness Programming Requires Genuine Medical Oversight
- 8.7 — Thermal and Mineral Spring Facilities Follow Updated Safety Regulation
- 8.8 — Travel Insurance and Emergency Evacuation Coverage Is Verified
- 8.9 — Substance-Related Wellness Practices Follow Genuine Safety Disclosure and Legal Compliance
- 8.10 — Facilitator Representations About Program Intensity Match Actual Reality

8.1 Pricing Transparency for International Wellness Guests

NON-NEGOTIABLE

An international guest receives a complete, written, all-inclusive cost estimate before travel is booked — covering the full program and commonly needed extras — not a partial quote that grows once the guest has already committed to travelling.

In plain terms: International wellness guests get a complete written cost before booking travel — programme, accommodation, meals, treatments, transfers, the usual extras — with nothing hidden.

Facility category	Crisis	Transition	Small	Standard
Applicability	N/A	Full	Full	Full

WHY THIS MATTERS

A guest who flies in for a week-long wellness retreat cannot walk away when the bill is double the quote. Add-on treatments, mandatory consultations, 'facility fees,' transfers, dietary supplements — each undisclosed extra is a breach of trust with a guest who has no recourse. An all-inclusive written estimate — everything included, everything excluded, what could change and why — in the guest's language, before travel is booked, is the basis of an ethical wellness tourism business.

WHAT GOOD LOOKS LIKE

- Every international guest receives a complete, written, all-inclusive estimate before booking.
- The estimate genuinely covers commonly needed extras, not just the base program fee.
- A transparent, defined process exists for any genuine cost change.

COMMON FAILURE MODES

- Estimates are verbal, partial, or given only after the guest has already committed to travel.
- The quote covers only the base program, with predictable extras added later.
- Cost increases appear on the final bill without prior communication.

WORKED EXAMPLE

IN PRACTICE

A 1,500-member wellness centre with a residential retreat programme for international guests.

BEFORE	Retreat prices covered the programme. Accommodation, meals, treatments, transfers, and consultations were charged separately on departure. Guests routinely paid 40% more than quoted. Reviews cited 'hidden costs.'
ACTION	An all-inclusive retreat estimate template was created per programme: programme, accommodation, all meals, included treatments, transfers, consultations — total; explicit list of optional extras with prices; conditions under which the price could change. Sent in the guest's language before booking with a signature. Any charge outside the estimate requires the guest's written agreement.
AFTER	The Monitor reviewed 12 retreat guest files with signed estimates matching final invoices. Complaints about cost: none in six months. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Compare the last ten retreat guests' quotes to their final bills.
2. Build an all-inclusive estimate template.
3. Send it before booking in the guest's language.
4. Require written agreement for extras.

The most common mistake: Quoting the programme and treating the accommodation as an extra.

SELF-ASSESSMENT QUESTIONS

1. Does every international guest receive a complete, written, all-inclusive estimate before booking travel? — *Written and complete, not a verbal figure that leaves room to grow later.*

Evidence: Written cost estimate documentation

2. Does the estimate cover commonly needed extras, not just the base program fee? — *Genuinely all-inclusive, not a narrow quote that*

predictably grows.

Evidence: N/A — tested directly

3. Is there a specific process for handling a genuine, unforeseeable cost change once the guest has arrived? — *A defined, transparent process, not an unexplained addition to the bill.*

Evidence: Cost change communication protocol

COMMON REASONS FOR A PARTIAL ANSWER

- **Estimates are written and complete for the primary program but not for commonly bundled extras.** — A guest comparing quotes needs the genuinely full picture, not just the headline program cost.
- **The estimate is provided in writing but only after initial travel arrangements are already underway.** — The protective value of advance pricing depends on it arriving before the guest's negotiating position weakens.
- **A cost change process exists but isn't proactively explained to guests in advance.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current pricing communication practice against genuine advance, all-inclusive standard.
Week 2	Build a complete, written estimate template covering commonly needed extras.
Week 3	Establish a transparent process for communicating any genuine cost change.
Ongoing	Audit final costs against original estimates for a sample of guests.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Cost estimate review	Reviews written estimates provided to a sample of recent international guests for completeness.
ASK	Guest cost experience interview	Asks a recent international guest whether their final cost matched what they were quoted before travel.

Method	What	Detail
DOCUMENT	Cost change protocol review	Reviews the process for communicating any genuine, unforeseeable cost change.

SUPERVISOR TIPS

- **Ask a recent international guest directly whether the final cost matched the original quote.** — This is the clearest, most direct test of genuine pricing transparency.
- **Ask to see a written estimate for a specific, real guest, not a generic template.** — A real example reveals whether the practice is genuinely followed, not just documented in policy.

EVIDENCE BASE

[36] WHO's guidance on financial protection in health systems identifies advance cost transparency as a determinant of genuine informed consent, a principle that applies with particular force when the guest has limited ability to seek a second opinion or negotiate after arrival.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

8.2 Language Access for International Guests

NON-NEGOTIABLE

International guests have access to a genuinely competent interpreter for program orientation, safety instructions, and any consent conversation — not an ad hoc arrangement using whichever staff member happens to speak some of the guest's language.

In plain terms: International guests have a competent interpreter for orientation, safety briefings, and any medical or programme discussion — not a staff member who 'speaks some English.'

Facility category	Crisis	Transition	Small	Standard
Applicability	N/A	Full	Adapted	Full

WHY THIS MATTERS

A safety briefing the guest did not understand is a briefing not given. A programme intensity explained through gestures is a programme the guest cannot judge. A medical screening (1.1) completed in a language the guest reads poorly is unreliable. For wellness tourism, language access covers: orientation and facility rules, safety briefings for every activity, the screening and any medical conversation, programme explanation and daily instructions, and complaints. A phone interpretation service and translated materials are the minimum; language-matched staff where possible.

WHAT GOOD LOOKS LIKE

- A genuinely trained, competent interpreter is used consistently.
- Interpreter access is arranged in advance, matched to the guest's language.
- Guests can explain back key safety instructions in their own words.

COMMON FAILURE MODES

- Whichever staff member happens to speak some of the language is used ad hoc.
- Interpreter arrangements are improvised on the day of arrival.
- Guests cannot explain back safety instructions.

WORKED EXAMPLE

IN PRACTICE

A wellness centre receiving guests from six language groups.

BEFORE

Orientation was in the local language with a staff member translating informally into English. Guests from other language groups understood little. A guest misunderstood the sauna safety briefing and stayed too long, fainting. Screening forms were in English only.

ACTION	Screening forms and safety briefings were translated into the six main languages. A phone interpretation service covers orientation, medical conversations, and complaints. Safety briefings for each activity are delivered with translated cards and interpreter where needed. Guest-facing staff learned key phrases. Interpreter use is documented.
AFTER	The Monitor reviewed translated materials, interpretation logs, and observed an orientation using the phone service. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List the languages of your international guests.
2. Translate screening forms and safety briefings into each.
3. Contract a phone interpretation service.
4. Document interpreter use for medical conversations.

The most common mistake: Delivering a sauna safety briefing the guest did not understand.

SELF-ASSESSMENT QUESTIONS

1. Is a genuinely competent interpreter used for program orientation, safety instructions, and consent conversations? — *Trained interpreter competency, not ad hoc bilingual staff pressed into service.*

Evidence: Interpreter engagement record

2. Is interpreter access arranged before the guest arrives, not improvised on the day? — *Planned in advance, matched to the guest's actual language.*

Evidence: N/A — tested directly

3. Can the guest explain back key safety instructions in their own words? — *Tests genuine understanding, not just that interpretation technically occurred.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **A trained interpreter is used for arrival orientation but not for ongoing daily program instructions.** — Safety guidance during the program carries real, ongoing importance, not only at arrival.
- **Interpreter access exists but isn't confirmed until the guest has already arrived.** — Advance confirmation avoids a scramble that risks falling back on ad hoc arrangements.
- **Interpretation occurs but understanding is never actively checked afterward.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current interpreter arrangements for international guests.
Week 2	Establish advance booking of trained interpreters matched to expected guest languages.
Week 3	Extend interpreter use to ongoing daily program instructions, not arrival alone.
Ongoing	Spot-check guest understanding after interpreted safety instructions.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Interpreter engagement review	Reviews records for genuine, trained interpreter engagement, not ad hoc bilingual staff use.
ASK	Advance arrangement interview	Asks staff how interpreter access is arranged before an international guest's arrival.
OBSERVE	Guest understanding check	Checks whether the guest can explain back key safety instructions.

SUPERVISOR TIPS

- **Ask specifically about interpretation for daily program safety instructions, not just arrival orientation.** — This is where interpreter use most commonly lapses.
- **Ask a guest to explain back a specific safety instruction in their own words.** — This tests genuine understanding, not just that an interpreter was present.

EVIDENCE BASE

[37] Professional interpreter use is consistently associated with improved comprehension, informed consent quality, and safety outcomes compared with ad hoc interpretation by untrained bilingual staff or fellow guests.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

8.3 Booking Agent and Facilitator Verification

NON-NEGOTIABLE

Any wellness tourism booking agent or facilitator referring guests to this facility is specifically verified — real business registration, a real, checkable track record — with the verification documented, not accepted based on the volume of guests they refer or how professional their marketing appears.

In plain terms: Any agent or booking platform that sends international guests is verified — real business, real track record — and bound by a written standard on what they may promise.

Facility category	Crisis	Transition	Small	Standard
Applicability	N/A	Full	Adapted	Full

WHY THIS MATTERS

Wellness tourism agents promise transformation, guaranteed results, medical outcomes. When the reality falls short, the guest blames the facility. Verification: registration confirmed; references; a signed agreement on permitted claims (no guarantees, no medical outcome promises), commission disclosure, and termination. Guests receive the facility's own programme description directly so they can compare what they were told.

WHAT GOOD LOOKS LIKE

COMMON FAILURE MODES

- Each facilitator is specifically verified for legitimate registration and track record.
- Verification is documented and periodically reconfirmed.
- A specific process reviews what facilitators actually represent to guests.

- Facilitators are accepted based on referral volume without specific verification.
- Verification, if it happened, was never reconfirmed after initial acceptance.
- No process exists to review what facilitators actually tell guests.

WORKED EXAMPLE

IN PRACTICE

A wellness centre receiving guests through four international agents.

BEFORE	Agents were engaged by email. One promised 'guaranteed 10 kg weight loss in 7 days' and 'medically supervised detox' — neither true. Guests arrived with expectations the facility could not meet. No agreements existed.
ACTION	An agent verification standard was written: registration confirmed; two references; a signed agreement on permitted representations (the facility's own programme descriptions only; no guarantees; no medical claims), commission disclosure, and termination for breach. All four agents were reviewed; one terminated. Guests receive the facility's programme description directly at booking.
AFTER	The Monitor reviewed three agent files with verification and agreements. Interviewed a guest who confirmed receiving the facility's own description. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List every agent and what they say about you online.
2. Verify each one's registration.
3. Sign an agreement on permitted claims.

4. Send guests your own description directly.

The most common mistake: An agent promising results the facility never claimed.

SELF-ASSESSMENT QUESTIONS

1. Is each booking agent or facilitator specifically verified for legitimate business registration and a checkable track record? — *Genuine, specific verification, not accepted based on referral volume or marketing professionalism alone.*

Evidence: Facilitator verification record

2. Is verification documented and periodically reconfirmed, not done once and assumed to remain valid indefinitely? — *An active, periodically reconfirmed process, not a one-time check.*

Evidence: Periodic reconfirmation record

3. Is there a specific process for reviewing what a facilitator actually tells guests about program intensity and content? — *Active oversight of facilitator representations, not an assumption they accurately represent the program.*

Evidence: Facilitator representation review process

COMMON REASONS FOR A PARTIAL ANSWER

- **Verification happens for new facilitator relationships but isn't reconfirmed for long-standing ones.** — A facilitator's legitimacy and practices can change over time even after an initial, valid verification.
- **Verification covers business registration but not the accuracy of their guest-facing representations.** — A legitimately registered facilitator can still misrepresent program intensity or content to guests.
- **Guests occasionally arrive with expectations that don't match what the facility actually offers.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current facilitator relationships for specific verification versus assumed legitimacy.
Week 2	Establish or strengthen documented verification for every facilitator relationship.

When	What
Week 3	Build a periodic reconfirmation schedule and a process for reviewing facilitator representations.
Ongoing	Review guest expectations against program reality as an indicator of facilitator accuracy.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Facilitator verification review	Reviews verification records for business registration and track record for each facilitator.
DOCUMENT	Reconfirmation schedule review	Reviews whether verification is periodically reconfirmed, not a one-time check.
ASK	Representation review interview	Asks staff how they review what facilitators actually tell guests about the program.

SUPERVISOR TIPS

- **Ask for the actual verification record for a specific, named facilitator.** — A specific, documented record is the real evidence of genuine verification, not assumed legitimacy.
- **Ask a recent international guest what they were told by their facilitator before arrival.** — This reveals whether facilitator representations actually match program reality.

EVIDENCE BASE

[38] Medical and wellness tourism governance literature consistently identifies unregulated facilitator and agent networks as a distinct risk category, separate from the operational quality of the receiving facility itself.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

8.4 International Guest Complaint and Redress Process

NON-NEGOTIABLE

International guests have access to a genuine complaint and redress process reachable from their home country, with real evidence complaints are addressed — not a process that functionally only works for a guest still physically present at the facility.

In plain terms: International guests can complain and seek redress from their home country — email, phone, web — and there is evidence complaints are addressed.

Facility category	Crisis	Transition	Small	Standard
Applicability	N/A	Full	Full	Full

WHY THIS MATTERS

A guest who returns home dissatisfied, or injured, cannot complain at the front desk. Without a remote route, they complain publicly. The process: email and web form in the guests' languages; a named person; response times; a redress policy (refund conditions, escalation). Evidence: complaints from abroad received and resolved.

WHAT GOOD LOOKS LIKE

- The complaint channel is genuinely reachable and usable from abroad.
- The channel accounts for relevant languages and time zone differences.
- Real, documented evidence shows complaints are genuinely addressed.

COMMON FAILURE MODES

- The complaint process functionally requires physical presence at the facility.
- No accommodation exists for language or time zone barriers.
- No documented evidence exists that complaints from returned guests are addressed.

WORKED EXAMPLE

IN PRACTICE

A wellness centre whose complaints process was in-person only.

BEFORE	No remote route. Guests complained on review sites. Two injury complaints from abroad went unanswered because they arrived by email to a general inbox nobody monitored.
ACTION	A dedicated international complaints email and web form were created in six languages; the guest relations manager is the named contact; 3-day acknowledgement, 21-day response; a redress policy with refund conditions and an external mediation option. The route is on every booking confirmation.
AFTER	The Monitor reviewed the log: 9 international complaints in six months, all responded to within timeframe, two with partial refunds. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Try to complain about your facility from abroad.
2. Create a dedicated email and web form in guests' languages.
3. Name a contact and set response times.
4. Write a redress policy.

The most common mistake: Reporting no international complaints because the email goes to an unmonitored inbox.

SELF-ASSESSMENT QUESTIONS

1. Is there a specific complaint channel genuinely reachable from the guest's home country? — *Genuine remote accessibility, not a channel that functionally only works locally.*
Evidence: Complaint channel documentation
2. Is the complaint channel accessible in relevant languages and time zones? — *Genuine accessibility accounting for real language and*

time zone barriers.

Evidence: N/A — tested directly

3. Is there real, documented evidence that complaints from returned guests are actually addressed? — *Genuine follow-through, not a channel that exists but produces no real response.*

Evidence: Complaint resolution record

COMMON REASONS FOR A PARTIAL ANSWER

- **A remote complaint channel exists but response times are significantly slower than for on-site concerns.** — A technically accessible channel that responds too slowly doesn't provide genuine redress.
- **The channel is accessible by email but responses aren't genuinely timed to the guest's time zone.** — Technical accessibility without genuine time zone awareness limits real, timely communication.
- **Complaints are received but resolution isn't consistently communicated back to the guest.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current complaint channel for genuine remote, language, and time zone accessibility.
Week 2	Establish or strengthen remote-accessible complaint intake in relevant languages.
Week 3	Establish documented resolution tracking with clear communication back to the guest.
Ongoing	Track response times and resolution rates for international guest complaints specifically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Complaint channel accessibility review	Reviews whether the complaint channel is genuinely reachable and usable from abroad.
DOCUMENT	Language and time zone accessibility review	Reviews whether the channel accounts for relevant languages and time zone differences.

Method	What	Detail
DOCUMENT	Resolution record review	Reviews documented evidence that complaints from returned guests are genuinely addressed.

SUPERVISOR TIPS

- **Ask for a real example of a complaint received from a guest after they had already returned home.** — A real example reveals whether the channel genuinely functions for exactly the guests who need it most.
- **Test the complaint channel's accessibility in a language other than the local one.** — This directly reveals genuine language accessibility, not an assumption of it.

EVIDENCE BASE

[39] Cross-border consumer redress mechanisms are identified in international tourism governance literature as a distinct requirement from domestic complaint processes, given the specific access barriers international travelers face after returning home.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

8.5 Travel Fatigue Is Factored Into Program Intensity, Not Ignored

NON-NEGOTIABLE

Program intensity for an arriving international guest genuinely accounts for real travel fatigue — jet lag, disrupted sleep, dehydration from flight — not beginning a high-intensity program immediately on arrival as though the guest hadn't just traveled at all.

In plain terms: A guest who arrived yesterday after a long flight does not start high-intensity training this morning — the programme accounts for jet lag, dehydration, and disrupted sleep.

Facility category	Crisis	Transition	Small	Standard
Applicability	N/A	Full	Adapted	Full

WHY THIS MATTERS

A guest who has flown twelve hours, crossed eight time zones, slept four hours, and is dehydrated is not physiologically ready for the programme they booked. Starting them at full intensity on day one causes fainting, injury, and cardiac stress. Travel fatigue must be assessed on arrival (hours travelled, time zones, sleep, hydration, symptoms) and the first day or two adapted: lower intensity, hydration, rest, gradual ramp. The programme design allows for it; the guest is told why.

WHAT GOOD LOOKS LIKE

- Program intensity genuinely accounts for real arrival fatigue.
- A specific, structured adjustment period precedes full intensity.
- Guests are specifically assessed for their actual travel impact.

COMMON FAILURE MODES

- Full-intensity programming begins immediately on arrival, regardless of travel.
- No structured adjustment period exists.
- Travel impact is assumed generically, not individually assessed.

WORKED EXAMPLE

IN PRACTICE

A wellness centre running seven-day intensive retreats for international guests.

BEFORE

The programme started at full intensity on the morning after arrival. Guests arriving from long-haul flights regularly fainted, vomited, or dropped out on day one. Staff attributed it to 'not being fit enough.'

ACTION

An arrival assessment was added: travel duration, time zones crossed, sleep, hydration, symptoms. Day one is a low-intensity orientation and hydration day for all long-haul arrivals; day two ramps to 60%; full intensity from day three.

	The seven-day programme was restructured to accommodate this. Guests are told at booking.
AFTER	The Monitor reviewed 20 arrival assessments and adapted day-one programmes; day-one adverse events fell from 6 per month to 0. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Count adverse events on day one of your retreats.
2. Add an arrival travel fatigue assessment.
3. Make day one low-intensity for long-haul arrivals.
4. Restructure the programme.

The most common mistake: Starting the retreat at full intensity the morning after a twelve-hour flight.

SELF-ASSESSMENT QUESTIONS

1. Does program intensity for an arriving guest genuinely account for real travel fatigue, not assume full readiness immediately? — *Real, deliberate adjustment for arrival fatigue, not intensity beginning as though travel hadn't occurred.*

Evidence: Arrival program adjustment documentation

2. Is there a specific, structured adjustment period before full-intensity programming begins? — *A real, defined adjustment period, not immediate full participation on arrival.*

Evidence: N/A — tested directly

3. Are guests specifically asked about their own travel experience — flight length, time zones crossed — to inform this adjustment? — *Genuine, individual assessment of actual travel impact, not a generic assumption applied to everyone.*

Evidence: Travel impact assessment

COMMON REASONS FOR A PARTIAL ANSWER

- **Adjustment happens for guests arriving from significantly different time zones but not for shorter, still fatiguing journeys.** — Genuine fatigue can result from travel that doesn't cross many time zones, and deserves the same consideration.

- **An adjustment period exists on paper but isn't consistently followed when a guest insists they feel ready.** — Genuine physiological depletion doesn't necessarily match a guest's own subjective sense of readiness.
- **Assessment happens but isn't genuinely used to inform the actual first-day program.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current arrival program design for genuine accounting of travel fatigue.
Week 2	Establish a structured adjustment period before full-intensity programming.
Week 3	Build a specific travel impact assessment informing actual first-day program design.
Ongoing	Confirm adjustment period practice holds even when a guest requests to begin immediately.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Arrival adjustment review	Reviews whether program intensity genuinely adjusts for arrival fatigue.
OBSERVE	Adjustment period observation	Observes whether a real, structured adjustment period precedes full-intensity programming.
DOCUMENT	Travel impact assessment review	Reviews whether guests are specifically asked about their actual travel experience.

SUPERVISOR TIPS

- **Ask what a guest arriving from a long-haul flight would actually do on their first day.** — A specific, real answer reveals genuine practice, not an assumption that adjustment happens.
- **Ask how staff would respond to a guest insisting they're ready for full intensity immediately.** — A specific, thoughtful answer reveals whether genuine physiological consideration holds against guest preference.

EVIDENCE BASE

[40] A Columbia University study of business travelers found frequent and extensive travel associated with increased cardiovascular risk factors including obesity, high blood pressure, and high cholesterol, with jet lag, poor sleep, and disrupted routine establishing genuine, real physical depletion that program intensity must account for on arrival.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

8.6 **Extreme or High-Intensity Wellness Programming Requires Genuine Medical Oversight**

NON-NEGOTIABLE

Any program pushing toward genuine physical extremes — intensive detox, extended fasting, high-altitude exertion, extreme temperature exposure — is genuinely overseen by a trained medical professional, not delivered by wellness staff alone regardless of how experienced they are in non-medical wellness practice.

In plain terms: Any programme that pushes the body to extremes — prolonged fasting, intensive detox, altitude, extreme heat or cold — has a doctor genuinely overseeing it: screening, monitoring, and authority to stop.

Facility category	Crisis	Transition	Small	Standard
Applicability	N/A	Full	Adapted	Full

WHY THIS MATTERS

Extended water fasting, 'detox' protocols, high-altitude exertion, extreme heat or cold exposure, intense caloric restriction — each has caused deaths in wellness settings. They are physiological stressors that can precipitate cardiac arrhythmia, electrolyte collapse, hypothermia, heat stroke, or kidney failure, especially in people with undisclosed conditions. Medical oversight means a licensed physician: screens every participant for that specific programme, sets participant-

specific limits, monitors (vital signs, bloods where indicated) during the programme, and has authority to stop it. A 'wellness consultant' is not medical oversight.

WHAT GOOD LOOKS LIKE

- Genuinely extreme programming is overseen by a trained medical professional.
- The medical professional is genuinely present or immediately accessible during the activity.
- A specific, defined threshold clearly identifies what triggers this requirement.

COMMON FAILURE MODES

- Extreme programming relies on wellness staff alone, without medical oversight.
- Medical input, if any, happens only in advance, not during the actual activity.
- No defined threshold exists; the need for oversight is left to informal judgment.

WORKED EXAMPLE

IN PRACTICE

A wellness centre offering a seven-day water fast and a cold-exposure programme.

BEFORE

The fasting programme was run by a nutritionist. No medical screening specific to fasting. No monitoring. A guest with undisclosed heart disease developed an arrhythmia on day five; another with a history of eating disorder relapsed. The cold programme had no temperature or duration limits.

ACTION

A physician was contracted for all extreme programmes: fasting-specific screening (cardiac, renal, electrolytes, eating disorder history, medications); daily vital signs and electrolytes on days 3, 5, and 7; participant-specific limits; authority to withdraw a participant. Cold exposure: physician-set limits by participant, monitored sessions, exclusion criteria. Programmes cannot run without the physician's sign-off.

AFTER

The Monitor reviewed the physician contract, screening records for 15 fasting participants, monitoring logs, and two withdrawals for medical reasons. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List every programme that pushes physiological extremes.
2. For each, name the physician overseeing it. If none, stop the programme until there is one.
3. Write programme-specific screening and monitoring.
4. Give the physician authority to stop.

The most common mistake: A nutritionist 'supervising' a seven-day fast — that is not medical oversight.

SELF-ASSESSMENT QUESTIONS

1. Is any genuinely extreme or high-intensity program overseen by a trained medical professional, not wellness staff alone? — *Real, medical oversight specifically, not general wellness expertise substituted for it.*

Evidence: Medical oversight documentation for extreme programming

2. Is the medical professional genuinely present or immediately accessible during the actual extreme activity, not consulted only in advance? — *Real, active presence or immediate accessibility during the activity itself, not a prior consultation alone.*

Evidence: N/A — tested directly

3. Is there a specific, defined threshold for what counts as "extreme," triggering this requirement, not left to informal judgment? — *A real, defined threshold, not an assumption staff will recognise when oversight is needed.*

Evidence: Extreme program threshold definition

COMMON REASONS FOR A PARTIAL ANSWER

- **Medical oversight is genuine for the most extreme offerings but the threshold isn't clearly defined for borderline programs.** — A clear, specific threshold prevents genuinely risky borderline programs from falling through an undefined gap.
- **A medical professional is consulted in program design but isn't genuinely present during the actual activity.** — Real-time

oversight during the activity itself is what actually protects a guest if something goes wrong in the moment.

- **Oversight exists for programs the facility itself labels extreme but not for guest-requested intensification of a standard program.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current extreme programming for genuine medical oversight versus wellness staff alone.
Week 2	Establish a specific, clear threshold defining what triggers mandatory medical oversight.
Week 3	Confirm medical presence or immediate accessibility during the actual activity, not consultation alone.
Ongoing	Apply the threshold consistently, including guest-requested intensification.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Medical oversight documentation review	Reviews evidence of genuine medical professional oversight for programs meeting the extreme threshold.
OBSERVE	Presence or accessibility observation	Confirms medical oversight is genuinely present or immediately accessible during the actual activity.
DOCUMENT	Threshold definition review	Reviews the facility's specific, defined threshold for what triggers mandatory medical oversight.

SUPERVISOR TIPS

- **Ask for the facility's specific, defined threshold for what counts as extreme programming.** — A specific, real threshold reveals genuine practice, not informal judgment.
- **Ask where the medical professional actually is during a specific extreme activity.** — A specific, confident answer reveals genuine real-time oversight, not advance consultation alone.

EVIDENCE BASE

[41] Documented analysis of the wellness retreat industry identifies a competitive push toward increasingly extreme treatment offerings, with certain extreme treatments carrying serious health risks particularly when not carried out by trained medical professionals.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

8.7 Thermal and Mineral Spring Facilities Follow Updated Safety Regulation

NON-NEGOTIABLE

Thermal and mineral spring bathing facilities genuinely follow current, updated safety regulation and international best practice — water quality, temperature monitoring, bather capacity — not outdated practice assumed adequate because it hasn't caused a documented problem yet.

In plain terms: Thermal pools and mineral springs follow current safety regulation — water quality testing, temperature limits, supervision, contraindication screening — not tradition.

Facility category	Crisis	Transition	Small	Standard
Applicability	N/A	Adapted	Adapted	Full

WHY THIS MATTERS

Thermal water harbours Legionella, Pseudomonas, and amoebae that cause fatal infections. High temperatures cause fainting, arrhythmia, and — in pregnancy — fetal harm. Unsupervised pools drown. Regulation (national bathing water rules, ISO/CEN standards, WHO guidance) sets water quality testing frequency and limits, maximum temperatures, supervision requirements, and contraindication screening (cardiac disease, pregnancy, intoxication). A facility following 'what we've always done' is following the standards of the year it opened.

WHAT GOOD LOOKS LIKE

- The facility genuinely follows current, updated safety regulation.
- Water temperature is genuinely, actively monitored.
- Bather capacity is genuinely enforced, including during high demand.

COMMON FAILURE MODES

- Practice is outdated, assumed adequate without genuine current compliance.
- Temperature monitoring is absent or purely assumed from reputation.
- Capacity limits are ignored during high-demand periods.

WORKED EXAMPLE

IN PRACTICE

A wellness centre with a natural thermal spring pool used for decades.

BEFORE

Water was tested annually. Temperature was 'natural' (up to 44°C). No supervision. No contraindication screening. Two guests had fainted in the previous year; one Legionella case had been linked to the facility.

ACTION

The current national thermal bathing regulation and WHO guidance were obtained. Water quality testing moved to weekly (microbiological) with defined action limits and a closure protocol. Maximum temperature set at 40°C with a cooler pool for longer immersion. A trained attendant supervises during opening hours. Contraindication signage and a screening question at check-in. Immersion time guidance posted.

AFTER

The Monitor reviewed weekly water test results (all within limits), temperature logs, the attendant rota, and check-in screening records. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Find the current thermal bathing regulation for your country.

2. Compare your water testing frequency and temperature to it.
3. Add supervision and contraindication screening.
4. Write a closure protocol for water failures.

The most common mistake: Testing thermal water annually — Legionella grows in weeks.

SELF-ASSESSMENT QUESTIONS

1. Does the facility genuinely follow current, updated water quality and safety regulation for thermal or mineral spring bathing? — *Real, current regulatory compliance, not outdated practice assumed adequate.*
Evidence: Water quality and safety compliance documentation
2. Is water temperature genuinely, actively monitored, not assumed stable without verification? — *Real, active monitoring, not an assumption based on the source's general reputation.*
Evidence: Temperature monitoring record
3. Is bather capacity genuinely enforced, not exceeded during high-demand periods? — *Real, enforced capacity limits, not capacity guidance ignored when demand is high.*
Evidence: Bather capacity enforcement record

COMMON REASONS FOR A PARTIAL ANSWER

- **Water quality testing happens but not at a genuinely sufficient frequency to catch a real, developing issue promptly.** — Testing frequency should genuinely reflect real risk, not a minimal, infrequent schedule.
- **Temperature monitoring is documented but the response process for out-of-range readings isn't clearly defined.** — Monitoring without a genuine, defined response doesn't provide real protective value on its own.
- **Capacity is generally respected but isn't consistently enforced during the facility's busiest periods.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current thermal and mineral spring practice against updated safety regulation and best practice.

When	What
Week 2	Establish or strengthen regular, sufficient water quality and temperature monitoring.
Week 3	Build a genuine, enforced bather capacity limit, including during high demand.
Ongoing	Audit compliance against current, updated regulatory requirements.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Regulatory compliance review	Reviews evidence of genuine, current compliance with water quality and safety regulation.
DOCUMENT	Temperature monitoring review	Reviews records of active, regular temperature monitoring.
OBSERVE	Capacity enforcement observation	Observes whether bather capacity limits are genuinely enforced, particularly during high demand.

SUPERVISOR TIPS

- **Ask to see the actual, current water quality testing records, not a general assurance of safety.** — A real, specific record reveals genuine, current compliance, not assumed adequacy.
- **Observe capacity enforcement during a genuinely busy period.** — This is where capacity limits are most likely to be informally relaxed.

EVIDENCE BASE

[42] Global Wellness Institute wellness policy specifically calls for updating regulations and following international best practices for regulating health and safety at thermal and mineral springs bathing establishments, reflecting genuine, documented gaps between historical practice and current safety standards.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

8.8 Travel Insurance and Emergency Evacuation Coverage Is Verified

CORE

Before high-intensity or remote-location programming, the facility genuinely verifies that an international guest holds adequate travel insurance, including emergency medical evacuation coverage — not assuming guests have arranged this themselves without confirming it.

In plain terms: Before an international guest does anything high-intensity or in a remote location, the facility confirms they have travel insurance that covers it, including emergency evacuation.

Facility category	Crisis	Transition	Small	Standard
Applicability	N/A	Full	Adapted	Full

WHY THIS MATTERS

A guest injured on a mountain trek, or suffering a cardiac event at an altitude retreat, may need helicopter evacuation and repatriation — costing tens of thousands. Standard travel insurance often excludes 'adventure' activities and altitude. A guest without cover faces a catastrophic bill or, worse, delayed evacuation while payment is arranged. The facility verifies before the activity: the guest's policy, its activity coverage, its evacuation coverage. Guests without adequate cover are offered the option to obtain it or excluded from the activity.

WHAT GOOD LOOKS LIKE

- Insurance and evacuation coverage are genuinely, actively verified before intensive programming.
- Verification specifically confirms evacuation coverage, not general insurance alone.
- A real, defined response addresses an identified coverage gap.

COMMON FAILURE MODES

- Coverage is assumed without genuine verification.
- Verification, if any, confirms general insurance without specifically checking evacuation coverage.
- Programming proceeds regardless of an identified coverage gap.

WORKED EXAMPLE

IN PRACTICE

A wellness centre running high-altitude trekking retreats.

BEFORE	Insurance was 'the guest's responsibility.' A guest with altitude sickness needed helicopter evacuation; her travel insurance excluded activities above 3,000 metres; she faced a €25,000 bill and the evacuation was delayed by payment issues.
ACTION	Insurance verification was added to booking for high-intensity and remote programmes: the guest provides their policy; the facility checks activity and altitude coverage and evacuation cover; guests without adequate cover are directed to a specialist insurer; no participation without verified cover. An evacuation arrangement with a provider was contracted.
AFTER	The Monitor reviewed 20 booking files with verified insurance and the evacuation contract. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List programmes that are high-intensity or remote.
2. Require insurance verification before booking each.
3. Check activity, altitude, and evacuation cover specifically.
4. Direct uncovered guests to a specialist insurer.

The most common mistake: Assuming the guest's travel insurance covers trekking at 4,000 metres.

SELF-ASSESSMENT QUESTIONS

1. Does the facility genuinely verify travel insurance and evacuation coverage before high-intensity or remote programming? — *Real, active verification, not an assumption guests have arranged adequate coverage themselves.*

Evidence: Insurance verification record

2. Does verification specifically confirm emergency medical evacuation coverage, not general travel insurance alone? — *Specific, genuine confirmation of evacuation coverage, not general insurance assumed to include it.*
Evidence: N/A — tested directly

3. Is there a specific process for what happens if a guest lacks adequate coverage, not simply proceeding regardless? — *A real, defined response, not intensive programming proceeding despite an identified coverage gap.*
Evidence: Coverage gap response process

COMMON REASONS FOR A PARTIAL ANSWER

- **Verification happens for the most remote programming but not consistently for moderately remote locations.** — Genuine remoteness, not a binary extreme/non-extreme distinction, should determine when verification matters.
- **Coverage is confirmed to exist but the specific evacuation limits aren't checked against genuine program risk.** — A policy's coverage limits should genuinely match the actual risk of the specific program a guest is undertaking.
- **A response process exists for identified gaps but isn't consistently applied when a guest is eager to proceed.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current insurance verification practice for genuine, specific evacuation coverage confirmation.
Week 2	Establish verification specifically before high-intensity or remote-location programming.
Week 3	Build a defined, consistently applied response for identified coverage gaps.
Ongoing	Confirm coverage limits genuinely match actual program risk level.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Verification record review	Reviews evidence of genuine insurance and evacuation coverage verification before intensive programming.
DOCUMENT	Evacuation coverage specificity review	Reviews whether verification specifically confirms evacuation coverage, not general insurance alone.
DOCUMENT	Coverage gap response review	Reviews the defined response when a guest lacks adequate coverage.

SUPERVISOR TIPS

- **Ask how the facility would specifically verify evacuation coverage for a real, upcoming guest.** — A specific, confident answer reveals genuine practice, not an assumption of adequate coverage.
- **Ask what happens if a guest arrives without adequate coverage for planned intensive programming.** — A specific, defined answer reveals whether the response process genuinely holds under real pressure.

EVIDENCE BASE

[43] Adequate travel insurance including emergency medical evacuation coverage is established as a genuine safety consideration for wellness tourism, particularly for programming in remote locations where local emergency care access may be limited.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

8.9 Substance-Related Wellness Practices Follow Genuine Safety Disclosure and Legal Compliance

NON-NEGOTIABLE

Any wellness practice involving substances with genuine physiological or psychoactive effect — including those

marketed as natural or traditional — follows genuine safety disclosure and confirmed legal compliance in the jurisdiction where it occurs, not offered without the guest genuinely understanding real risk or legal status.

In plain terms: Any wellness practice using substances with real physiological or psychoactive effects — plant preparations, ceremonial substances, high-dose supplements — has honest safety disclosure, screening, and legal compliance.

Facility category	Crisis	Transition	Small	Standard
Applicability	N/A	Full	Full	Full

WHY THIS MATTERS

Ayahuasca, psilocybin, kambo, high-dose supplements, IV vitamin protocols — wellness tourism increasingly involves substances with genuine effects and genuine risks: cardiac interactions, psychiatric decompensation, drug interactions, and in many jurisdictions, illegality. A facility offering these must: know the legal status where it operates; disclose the real risks honestly (not 'natural and safe'); screen for contraindications (cardiac disease, psychiatric history, medications, pregnancy); have medical support available; and obtain specific informed consent. A facility that cannot meet these should not offer the practice.

WHAT GOOD LOOKS LIKE

- Genuine safety disclosure accompanies any substance-related wellness practice.
- Legal compliance is genuinely confirmed for the actual jurisdiction.
- Guests genuinely understand both risk and legal status before participating.

COMMON FAILURE MODES

- Disclosure is absent, with safety assumed from natural or traditional framing alone.
- Legal status is assumed, not genuinely confirmed.
- Guests participate without genuine understanding of risk or legality.

WORKED EXAMPLE

IN PRACTICE

A wellness centre offering plant-medicine ceremonies and IV vitamin protocols.

BEFORE

Ceremonies were described as 'ancient healing.'
No contraindication screening. A guest on an SSRI participated and developed serotonin syndrome. The legal status of the substance was unclear. IV protocols were administered by a non-clinician.

ACTION

Legal counsel confirmed the status of each substance; one practice was discontinued as unlawful. For permitted practices: honest written risk disclosure; a medical screening (cardiac, psychiatric, medications, pregnancy) by a physician; exclusion criteria applied; a clinician present; specific informed consent; emergency protocol. IV protocols moved to nurse administration under physician oversight with the same screening.

AFTER

The Monitor reviewed the legal review, screening records, consent forms, and the clinician presence log. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List every practice involving a substance with physiological effect.
2. Confirm the legal status of each with counsel.
3. Write honest risk disclosure and medical screening for each.
4. Require a clinician present.

The most common mistake: Calling a psychoactive substance 'natural' as if that made it safe.

SELF-ASSESSMENT QUESTIONS

1. Does any substance-related wellness practice come with genuine safety disclosure, not assumed safe from natural framing? — *Real*

disclosure of actual risk, not an assumption natural framing means no risk.

Evidence: Substance-related practice disclosure documentation

2. Is legal compliance in the actual jurisdiction genuinely confirmed, not assumed? — *Real, confirmed legal status, not assumed from traditional use elsewhere.*

Evidence: Legal compliance verification

3. Does the guest genuinely understand both risk and legal status before participating? — *Real, demonstrated understanding, not participation offered without informed context.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Disclosure covers general risk but doesn't specifically address genuine interaction risk with medications or conditions.** — Real, specific interaction risk deserves the same genuine disclosure as general practice risk.
- **Legal compliance was confirmed at some point but hasn't been reconfirmed as regulation has changed.** — Legal status can genuinely change, and confirmation should reflect current, not historical, regulation.
- **Disclosure happens but isn't consistently verified as genuinely understood before participation.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current substance-related wellness practices for genuine safety disclosure and legal compliance.
Week 2	Establish specific disclosure covering real physiological risk and interaction considerations.
Week 3	Confirm current legal compliance for the actual jurisdiction.
Ongoing	Reconfirm legal compliance as regulation changes.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Disclosure documentation review	Reviews genuine safety disclosure provided for any substance-related wellness practice.
DOCUMENT	Legal compliance review	Reviews confirmed legal compliance verification for the actual jurisdiction.
ASK	Guest understanding interview	Asks a guest what they understand about the risk and legal status of a substance-related practice offered.

SUPERVISOR TIPS

- **Ask a guest what they were told about the risk and legality of a specific substance-related practice.** — A specific, real answer reveals genuine disclosure and understanding, not an assumption of safety.
- **Ask how the facility confirmed the practice is genuinely legal in this specific jurisdiction.** — A specific, confident answer reveals genuine verification, not assumed legality.

EVIDENCE BASE

[44] Global Wellness Institute wellness policy specifically calls for educating wellness travelers on the regulatory and safety issues for substances with cognitive or psychoactive effect used in some wellness contexts, establishing genuine disclosure as necessary practice, distinct from assumed safety based on natural or traditional framing.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

8.10 Facilitator Representations About Program Intensity Match Actual Reality

NON-NEGOTIABLE

What a booking facilitator represents about a program's actual physical intensity and demands genuinely matches

the program guests actually experience — not marketed as gentler or less demanding than reality to secure a booking, leaving guests to discover the genuine intensity only on arrival.

In plain terms: What the booking agent says about how hard the programme is matches what the guest actually experiences — no 'gentle retreat' that turns out to be bootcamp, or vice versa.

Facility category	Crisis	Transition	Small	Standard
Applicability	N/A	Full	Adapted	Full

WHY THIS MATTERS

A guest who booked a 'gentle yoga retreat' and finds six hours of intense training daily is at physical risk and will leave angry. A guest who booked 'intensive transformation' and finds gentle stretching feels cheated. Mismatch between representation and reality is both a safety issue (the guest was not screened or prepared for what they will do) and a trust issue. The facility must define each programme's intensity clearly, communicate it to agents in writing, and check that agents represent it accurately — including asking guests on arrival what they were told.

WHAT GOOD LOOKS LIKE

- The facility specifically verifies facilitator intensity representations against actual reality.
- A real, active process identifies and corrects facilitator misrepresentation.
- Guests are specifically asked whether the program matched expectations.

COMMON FAILURE MODES

- Intensity representation accuracy isn't specifically checked, only general facilitator legitimacy.
- Misrepresentation patterns are tolerated without correction.
- Guests aren't asked whether their experience matched what they were told to expect.

WORKED EXAMPLE

IN PRACTICE

A wellness centre with programmes ranging from restorative to intensive.

BEFORE	Agents described programmes in their own words. A guest with a cardiac history booked a 'relaxation retreat' that was actually high-intensity; she had not been screened for that intensity. Another booked 'intensive' and got restorative. Arrival surveys showed 30% of guests had a different understanding than the programme's actual intensity.
ACTION	Each programme received a defined intensity rating (1–5) with a plain description of a typical day, hours of activity, and physical demands. Agents receive these in writing and must use them. Booking confirmations include the rating. Guests are asked on arrival what they were told; mismatches are logged and raised with the agent. Screening intensity matches the programme rating.
AFTER	The Monitor reviewed the programme intensity descriptions, agent communications, and arrival surveys (mismatch down to 4%). Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Rate each programme's intensity 1–5 with a description of a typical day.
2. Send the ratings to every agent in writing.
3. Put the rating on every booking confirmation.
4. Ask guests on arrival what they were told.

The most common mistake: Letting agents describe intensity in their own words — 'transformative' means something different to everyone.

SELF-ASSESSMENT QUESTIONS

1. Does the facility specifically verify that facilitator representations of program intensity match actual reality? — *Real, specific verification of intensity representation, not general facilitator legitimacy checking*

alone.

Evidence: Intensity representation verification process

2. Is there a specific process for identifying and correcting a facilitator who consistently misrepresents intensity? — *A real, active process, not passive tolerance of a pattern of misrepresentation.*

Evidence: Misrepresentation correction process

3. Are guests specifically asked, on arrival, whether the program matches what they were told to expect? — *Real, direct verification from the guest's own perspective, not assumed accuracy.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Verification happens for new facilitator relationships but isn't revisited if intensity representations drift over time.** — A facilitator's representations can genuinely change, and verification should track this on an ongoing basis, not only at initial relationship setup.
- **Guest feedback on expectation match is gathered but not systematically connected back to a specific facilitator.** — Feedback that isn't traced to its source doesn't provide the genuine, actionable signal this criterion depends on.
- **A correction process exists but hasn't been applied even when a real pattern was identified.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current facilitator oversight for genuine intensity representation verification.
Week 2	Establish a process specifically checking representation accuracy against actual program reality.
Week 3	Build a genuine correction process for identified misrepresentation patterns.
Ongoing	Gather and trace guest expectation-match feedback to specific facilitators.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Intensity verification process review	Reviews the specific process for verifying facilitator intensity representations against actual program reality.
DOCUMENT	Misrepresentation correction review	Reviews the process for identifying and correcting a facilitator with a pattern of misrepresentation.
ASK	Arrival expectation check	Asks a recent guest whether the actual program matched what their facilitator told them to expect.

SUPERVISOR TIPS

- **Ask a recent guest directly whether the actual program matched what they were told to expect.** — A real, direct answer reveals genuine accuracy, not assumed facilitator reliability.
- **Ask for a real example of a facilitator being corrected for misrepresenting program intensity.** — A real example, or its honest absence, reveals whether this process genuinely functions.

EVIDENCE BASE

[45] Accurate representation of actual program intensity and content, verified against real guest experience, is established as a specific, necessary dimension of facilitator oversight in wellness and medical tourism governance, distinct from general facilitator legitimacy verification alone.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

← **Fitness & Wellness Standards — all standards**

Self-assess against these criteria →

← **Standard 7 — Governance & Staffing**

Standard 9 — Rehabilitation

→

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ASF STANDARDS · FITNESS & WELLNESS · STANDARD 9

Standard 9 — Rehabilitation

5 criteria · 2 non-negotiable · 2 core · 1 standard-level · Version 1.0

CRITERIA IN THIS STANDARD

**9.1 — Medical Clearance
Required Before Post-Injury
Programming**

**9.2 — Qualified Staff Deliver
Post-Injury Programming**

**9.3 — Individualized Program
Based on Functional
Assessment**

**9.4 — Pain and Warning Sign
Recognition, With a Stop
Protocol**

**9.5 — Communication with
Referring Clinician Where
Applicable**

9.1 Medical Clearance Required Before Post-Injury Programming

NON-NEGOTIABLE

A member returning to exercise programming after a significant injury, surgery, or medical event has documented medical clearance before participating, with any clearance-stated restrictions genuinely built into the program — not a general waiver treated as sufficient regardless of the member's actual medical history.

In plain terms: A member coming back after an injury or surgery has real medical clearance before starting — and any restrictions that clearance mentions actually shape

the program, not just a signed liability form.

Facility size	Small	Standard
Applicability	Full	Full

WHY THIS MATTERS

A general liability waiver addresses legal risk to the facility but says nothing about whether a specific activity is medically appropriate for this particular member at this particular point in their recovery — these are genuinely different documents serving different purposes, and treating one as a substitute for the other overlooks a real safety gap. A fitness facility operates in a fundamentally different risk context than a clinical rehabilitation setting, which makes verifying genuine medical clearance, rather than assuming general fitness is automatically safe post-injury, specifically important here.

WHAT GOOD LOOKS LIKE

- Documented medical clearance is actually obtained before programming begins.
- Stated restrictions are genuinely built into the program, not overlooked.
- A documented process exists for a member disclosing an injury after already starting.

COMMON FAILURE MODES

- A general liability waiver is treated as equivalent to medical clearance.
- Restrictions noted in clearance are overlooked once programming starts.
- No process exists for a member who discloses an injury mid-membership.

WORKED EXAMPLE

IN PRACTICE	
<i>A member returning to the gym six weeks after shoulder surgery.</i>	
BEFORE	The member signed the facility's standard liability waiver at check-in, as every member does, with no specific medical clearance requested for post-surgical return to activity, and was given the same general orientation as any new member.
ACTION	The facility built a specific intake question flagging recent injury or surgery, triggering a

requirement for documented medical clearance before any programming begins, with clearance-stated restrictions logged in the member's file.

AFTER

The Monitor reviewed the member's file and found documented clearance with a specific overhead-lifting restriction, cross-checked against the actual exercise program to confirm the restriction was respected. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Build a specific intake question flagging recent injury or surgery.
2. Require documented medical clearance, distinct from the general liability waiver.
3. Build a process for cross-checking clearance restrictions against the actual program.

The most common mistake: Treating the standard liability waiver, signed by every member, as equivalent to genuine medical clearance for someone returning after a significant injury or surgery, when these documents address entirely different questions.

SELF-ASSESSMENT QUESTIONS

1. Is documented medical clearance actually obtained before programming begins, not a general liability waiver treated as equivalent? — *A liability waiver addresses legal risk, not whether the specific activity is medically appropriate for this member right now.*

Evidence: Medical clearance record

2. Are specific restrictions stated in the clearance genuinely built into the program, not overlooked once the member starts? — *A clearance noting a lifting restriction, for instance, needs to actually shape the exercises assigned.*

Evidence: Program-to-clearance cross-check

3. Is there a documented process for what happens if a member discloses a significant injury or medical event after already starting? — *Not only a pre-enrollment check, since a member's medical situation*

can change at any point.
Evidence: Written process

COMMON REASONS FOR A PARTIAL ANSWER

- Clearance is obtained but restrictions aren't consistently cross-checked against the program.
- No process exists for a mid-membership injury disclosure.

IMPLEMENTATION PLAN

When	What
Week 1	Build a specific intake question flagging recent injury or surgery.
Week 2	Require medical clearance distinct from the general waiver.
Week 3	Build a restriction cross-check process against the actual program.
Ongoing	Build a mid-membership disclosure process.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Clearance-to-program cross-check	Checks a member's medical clearance restrictions against their actual assigned exercise program.

EVIDENCE BASE

World Health Organization. Rehabilitation 2030: A Call for Action. Geneva: WHO; 2023.

9.2 Qualified Staff Deliver Post-Injury Programming

NON-NEGOTIABLE

Post-injury or post-surgical return-to-activity programming is delivered or directly overseen by staff with specific qualification in this area, not a general fitness instructor without the relevant training applying standard programming regardless of the member's recovery status.

In plain terms: The staff member working with a post-injury or post-surgical member actually has real, specific qualification for this — not just general fitness training applied to a situation that needs more.

Facility size	Small	Standard
Applicability	Full	Full

WHY THIS MATTERS

General fitness certification, while appropriate for standard programming, doesn't necessarily cover the specific considerations of post-injury or post-surgical exercise — progression pacing, warning signs specific to a healing tissue, and when a modification is genuinely needed. A member in active recovery handled identically to any other general fitness client, by staff without the specific relevant training, is a real and specific risk this criterion exists to address.

WHAT GOOD LOOKS LIKE

- The delivering staff member holds genuine, verifiable post-injury or return-to-activity qualification.
- A clear, working distinction exists between standard and post-injury programming.
- Qualification is verified and current, not assumed from general experience.

COMMON FAILURE MODES

- A general fitness instructor delivers post-injury programming without specific qualification.
- No real distinction exists between this and any other member's standard program.
- Qualification is assumed from years of general experience rather than verified credentials.

WORKED EXAMPLE

IN PRACTICE

A facility assigning staff to post-injury clients.

BEFORE

Any available trainer was assigned to a post-surgical member based on scheduling convenience, with no check on whether that specific trainer held post-injury or return-to-activity qualification beyond their general fitness certification.

ACTION	The facility built a specific qualification requirement for post-injury programming, with a credential verification record kept on file and a clear internal flag identifying which staff are qualified to take these specific clients.
AFTER	The Monitor reviewed the credential record for the staff member currently working with a post-surgical member and confirmed genuine, current post-injury qualification. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check what qualification staff currently hold for post-injury programming specifically.
2. Build a credential verification record for this specific qualification.
3. Build an internal flag identifying which staff are qualified for these clients.

The most common mistake: Assigning any available trainer to a post-injury member based on scheduling convenience rather than checking whether that specific trainer holds genuine, verifiable qualification beyond general fitness certification.

SELF-ASSESSMENT QUESTIONS

1. Does the staff member delivering this specific programming hold genuine, verifiable qualification in post-injury or return-to-activity exercise, not just general fitness certification? — *General fitness certification doesn't necessarily cover the specific considerations of post-injury or post-surgical programming.*

Evidence: Credential verification record

2. Is there a clear, working distinction between standard fitness programming and this specialized post-injury programming? — *Not treated identically to any other member's general fitness plan.*

Evidence: Program distinction documentation

3. Is qualification verified and current, not assumed from a staff member's general experience? — *Verifiable through an actual credential record, not informal reputation.*

Evidence: Current credential file

COMMON REASONS FOR A PARTIAL ANSWER

- Staff have relevant experience but lack a verifiable specific credential.
- No internal flag distinguishes which staff can take post-injury clients.

IMPLEMENTATION PLAN

When	What
Week 1	Audit current staff qualification for post-injury programming specifically.
Week 2	Build a credential verification record.
Week 3	Build an internal qualified-staff flag system.
Ongoing	Re-verify credential currency on a defined schedule.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Credential verification	Checks the qualification record of the staff member assigned to a specific post-injury client.

EVIDENCE BASE

World Health Organization. Rehabilitation in Health Systems. Geneva: WHO; 2017.

9.3 Individualized Program Based on Functional Assessment

CORE

The return-to-activity program is built from a documented functional assessment specific to the member's injury or condition, progressing at a pace matched to genuine readiness, not a generic program applied regardless of the member's actual recovery stage.

In plain terms: The program is genuinely built around this member's actual recovery stage and progresses at their real pace — not a fixed timeline applied regardless of how they're actually doing.

Facility size	Small	Standard
Applicability	Full	Full

WHY THIS MATTERS

Two members with the same type of injury can be at genuinely different points in actual recovery readiness, shaped by factors like time since injury, healing progress, and individual response to activity — applying an identical program by injury type alone overlooks this real variation. Progressing on a fixed calendar timeline rather than on the member's actual demonstrated functional response carries a genuine re-injury risk, which is specifically why readiness-based, not calendar-based, progression matters here.

WHAT GOOD LOOKS LIKE

- A documented functional assessment is actually performed, not a generic program by injury type.
- Progression genuinely matches demonstrated readiness, not a fixed timeline.
- The program is reassessed and adjusted as function changes.

COMMON FAILURE MODES

- A generic program is applied by injury type without individual assessment.
- Progression follows a fixed calendar regardless of actual readiness.
- The program set at the start is never revisited as the member progresses.

WORKED EXAMPLE

IN PRACTICE

Two members returning after similar ACL reconstruction surgeries.

BEFORE

Both members were placed on an identical week-by-week return-to-activity timeline, despite one demonstrating faster strength recovery and better movement control than the other during their initial sessions.

ACTION

The facility built a functional readiness assessment at each session, with progression criteria explicitly tied to demonstrated function rather than calendar weeks, allowing each

member's pace to genuinely diverge based on their own response.

AFTER

The Monitor compared the two members' progression records and found genuinely different pacing reflecting their distinct functional assessments, not an identical calendar-based plan. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Build a functional readiness assessment used at each session, not just intake.
2. Define progression criteria tied to demonstrated function, not calendar time.
3. Compare several current member progressions to check for genuine individualization.

The most common mistake: Applying a fixed week-by-week progression timeline by injury type, rather than genuinely individualizing the pace based on each member's actual, demonstrated functional readiness.

SELF-ASSESSMENT QUESTIONS

1. Is a documented functional assessment actually performed before the program is built, not a generic program applied by injury type alone? — *Two members with the same injury can be at very different points in genuine recovery readiness.*

Evidence: Functional assessment record

2. Does progression genuinely match the member's demonstrated readiness, not a fixed timeline applied regardless of how they're actually responding? — *Progressing on a calendar rather than on actual functional response risks re-injury.*

Evidence: Progression criteria documentation

3. Is the program reassessed and adjusted as the member's function changes? — *A program fixed at the start may no longer reflect genuine progress or setback.*

Evidence: Program revision history

COMMON REASONS FOR A PARTIAL ANSWER

- An assessment happens at intake but progression still follows a fixed calendar.
- The program is rarely revisited once set.

IMPLEMENTATION PLAN

When	What
Week 1	Build a functional readiness assessment for use at each session.
Week 2	Define readiness-based, not calendar-based, progression criteria.
Week 3	Review several current member programs for genuine individualization.
Ongoing	Reassess programs at defined intervals as members progress.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Comparative progression review	Compares progression records across several members with similar injuries for genuine individualization.

EVIDENCE BASE

World Health Organization. Rehabilitation 2030: A Call for Action. Geneva: WHO; 2023.

9.4

Pain and Warning Sign Recognition, With a Stop Protocol

CORE

Staff delivering post-injury programming are trained to recognize warning signs — pain beyond expected levels, swelling, abnormal movement compensation — with a clear protocol to stop or modify the activity and refer back to medical care when these signs appear.

In plain terms: Staff genuinely know what warning signs mean “stop” for this specific member, and there’s a real pathway back to medical care when those signs show up — not vague general caution.

Facility size	Small	Standard
Applicability	Full	Full

WHY THIS MATTERS

Generic caution — “stop if it hurts” — is considerably less useful than specific, condition-relevant warning signs that staff genuinely know to watch for in this particular member’s recovery. A stop protocol that exists in training content but has never actually been used, or a referral pathway that’s vague about where the member should actually go, provides limited real protection when a genuine warning sign appears during an actual session.

WHAT GOOD LOOKS LIKE

- Staff describe specific warning signs relevant to the member’s actual condition.
- A documented instance exists of a session being stopped or modified for this reason.
- A clear referral pathway back to medical care exists when warning signs appear.

COMMON FAILURE MODES

- Staff give only vague general caution, not condition-specific warning signs.
- No example exists of the stop protocol ever actually being used.
- No clear referral pathway exists; the member is just told to “see a doctor.”

WORKED EXAMPLE

IN PRACTICE

A member returning after a knee injury showing unusual swelling mid-session.

BEFORE

The trainer noticed some swelling but, having only general caution rather than specific knowledge of what level of swelling was concerning for this particular injury, continued the

	planned session rather than stopping or seeking guidance.
ACTION	The facility built condition-specific warning sign training as part of the post-injury qualification requirement, with a documented stop protocol and a clear referral pathway back to the member's own clinician or an urgent care option.
AFTER	The Monitor reviewed a subsequent case where a trainer correctly identified concerning swelling, stopped the session, and documented the referral back to the member's physical therapist. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Build condition-specific warning sign training, not just general caution.
2. Build a documented stop protocol staff are trained to actually use.
3. Build a clear referral pathway back to medical care.

The most common mistake: Training staff only in general caution — “stop if there’s pain” — rather than specific, condition-relevant warning signs that would actually help them recognize when something genuinely needs attention for this particular member’s recovery.

SELF-ASSESSMENT QUESTIONS

1. Can staff describe specific warning signs relevant to this member’s condition, not just a vague general awareness? — *Specific, condition-relevant signs, not generic caution.*
Evidence: Staff interview
2. Is there a documented instance of a session being stopped or modified due to a warning sign, where applicable? — *Evidence the protocol genuinely functions, not just exists as training content.*
Evidence: Stop/modify record
3. Is there a clear referral pathway back to medical care when warning signs appear? — *Not just stopping the activity, but a genuine*

next step for the member.
Evidence: Referral pathway documentation

COMMON REASONS FOR A PARTIAL ANSWER

- Staff have general awareness but can't name condition-specific signs.
- A referral pathway exists but isn't specific or clearly communicated.

IMPLEMENTATION PLAN

When	What
Week 1	Build condition-specific warning sign training content.
Week 2	Build a documented stop protocol.
Week 3	Build a clear, specific referral pathway.
Ongoing	Review any stop/modify event for protocol adherence.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Staff interview	Asks staff to describe specific, condition-relevant warning signs for a current post-injury client.

EVIDENCE BASE

World Health Organization. Rehabilitation in Health Systems. Geneva: WHO; 2017.

9.5 Communication with Referring Clinician Where Applicable

STANDARD

Where a member's post-injury programming was initiated on referral from a physician or physical therapist, genuine communication with that clinician occurs at meaningful points during the program, not a one-time intake with no further contact.

In plain terms: Where a referral exists, the facility genuinely stays in touch with that clinician as the member progresses — not silence after the first intake conversation, and always with the member’s real consent.

Facility size	Small	Standard
Applicability	Full	Full

WHY THIS MATTERS

A referring physician or physical therapist who hears nothing after the initial intake has no real opportunity to adjust their own ongoing guidance based on how the member is actually progressing in the fitness setting — this is specifically a gap since the fitness facility often sees the member more frequently than the referring clinician does during this phase. Communication with an outside clinician necessarily involves the member’s personal health information, which makes their own genuine, documented consent a real requirement here, not an afterthought.

WHAT GOOD LOOKS LIKE

- Genuine two-way communication exists with the referring clinician, not just intake.
- Communication happens at meaningful points, not only a fixed arbitrary interval.
- Member consent for this communication is documented.

COMMON FAILURE MODES

- The referring clinician hears nothing after the initial intake conversation.
- Communication, where it happens, is rote and content-light.
- No documented member consent exists for sharing information with the clinician.

WORKED EXAMPLE

IN PRACTICE

A member referred by a physical therapist for continued post-rehab conditioning.

BEFORE

The facility received the referral and an initial intake note from the physical therapist, with no further contact during the following three months

	of programming, despite the member experiencing a notable setback partway through.
ACTION	The facility obtained documented member consent for ongoing communication with the referring clinician, with a policy to contact them at any significant change or setback, not only a fixed interval.
AFTER	The Monitor reviewed a subsequent case where a setback triggered a documented, consented communication to the referring physical therapist, who adjusted their own follow-up guidance in response. Criterion verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Build a documented member consent process for clinician communication.
2. Define meaningful trigger points for contact, not only a fixed interval.
3. Check whether referring clinicians currently hear anything beyond intake.

The most common mistake: Receiving a referral and an initial intake note from a physician or physical therapist, then providing no further communication during the actual course of programming even when something clinically significant occurs.

SELF-ASSESSMENT QUESTIONS

1. Where a referral exists, is there genuine two-way communication with the referring clinician, not silence after the initial intake? — *A referring clinician with no further contact has no opportunity to adjust their own guidance based on how the member is actually progressing.*

Evidence: Communication record

2. Does communication happen at meaningful points — a significant change, a concern — not only a fixed, arbitrary interval? —

Genuinely responsive communication, not a mechanical check-the-box update.

Evidence: Communication trigger policy

3. Is member consent for this communication documented, respecting their privacy? — *Communication with an outside clinician requires the member’s genuine, documented consent.*
Evidence: Consent record

COMMON REASONS FOR A PARTIAL ANSWER

- **Consent is obtained but communication rarely actually occurs afterward.**
- **No clear trigger criteria exist for when to contact the referring clinician.**

IMPLEMENTATION PLAN

When	What
Week 1	Build a documented member consent process.
Week 2	Define meaningful communication trigger points.
Week 3	Brief staff on when and how to contact referring clinicians.
Ongoing	Spot-check whether communication genuinely occurs when triggered.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Consent and communication record review	Checks for documented member consent and genuine, content-specific communication with the referring clinician.

EVIDENCE BASE

World Health Organization. Rehabilitation in Health Systems. Geneva: WHO; 2017.

← **Fitness & Wellness Standards — all standards**

Self-assess against these criteria →

← **Standard 8 — Medical Tourism**

