Duke Center for Living
at Fearrington

Physical Address: 100 Clynelish Close • Pittsboro, NC 27312
Mailing Address: 3000 Galloway Ridge • Pittsboro, NC 27312
Phone: 919-545-2133 • Fax: 919-545-2687

Membership Medical Freeze Request

Please print clearly. Return the completed form to Member Services at DCFL.

PLEASE NOTE:
Please complete a Medical Freeze Request as soon as it is possible to do so. Requests for Medical Freeze require a written note from your physician and are subject to the approval of the Member Services Manager.

1. Complete Member Information.

Member Name _____

Phone Number (Home) _____ (Cell) _____

2. Identify Medical Freeze Period and Reason.

- *Freeze may be granted for a **minimum of one month to a maximum of 6 months**. Billing of regular monthly membership fees will resume after the end date or after 6 months, whichever occurs first, if additional documentation from physician is not received.*
- ***A physician's note clearly stating the reason for the request and the approximate time frame for the absence must be attached. Alternatively, the physician may fax the note to DCFL at 919-545-2687. Physician's note must be received before freeze can be put into effect.***
- *Additional documentation will be required for periods beyond half of the membership term.*
- *A physician's clearance is required to reactivate membership.*
- *There is no fee for a medical freeze.*
- *Membership contract term will be extended by the number of months of approved medical freeze.*

Start Date _____ **End Date** _____

Reason _____

☐ **Physician note is attached.** ☐ **Physician will fax note to DCFL (919-545-2687).**

I hereby agree that the above information is accurate and I authorize the Duke Center for Living and Galloway Ridge Inc. to amend my Membership Agreement and billing status accordingly.

Member Signature _____ **Date** _____

FOR OFFICE USE ONLY:
Change entered: _____ Documentation Attached: ☐ Yes ☐ No

Contract extended to: _____

Revised: May 16, 2013

Medical Freeze

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