

Request for Change in Membership Status

Print clearly. Check and complete the relevant section. Return completed form to DCFL Member Services Desk.

PLEASE NOTE: Requests must be received 30 days in advance of the requested start date and are subject to the Member Services Manager's approval.

1. Complete Member Information:

Member(s) Name _____

Cell # _____ E-mail _____

2. Type of Membership Change Requested (Please check one):

VACATION FREEZE

- Freeze may be granted for a **minimum of one month and a maximum of 6 months, in full month increments only. Freeze does not have to begin on the first of the month.**
- Cost of Freeze = \$12 per month per member

Start Date: _____ End Date: _____ Total # of Months: _____ Total Cost: \$ _____

MEDICAL FREEZE

- Freeze may be granted for a **minimum of one month and a maximum of 6 months, in full monthly increments only. Freeze does not have to begin on the first of the month.**
- A physician's note** clearly stating the reason for the request must be either attached or faxed to DCFL at 919-545-2687. **Physician's Note must be received to implement the freeze.**
- There is no charge for the freeze. If a note is not received you will be charged \$12 per month.**

Start Date: _____ End Date: _____ Reason _____

Physician Note is attached Physician will FAX note to DCLF (919-545-2687)

TERMINATION

- May be granted under the following circumstances and with proper written documentation. Members may not use services that are on the canceled account without incurring additional charges.**

Relocation – Membership may be canceled due to relocation of 20 or more miles from the facility.

Medical– Membership may be canceled with written documentation from a member's physician stating that the member is directed to discontinue use of the facility and services.

Death – Memberships will be terminated upon notification of death, with written note from the estate executor.

Dissatisfied

30-Day Advance Notice on Monthly Contracts. Annual Contract will be charged 2 months of dues for early termination.

Termination Date: _____ Reason _____

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 _____

OR STAFF USE ONLY

Membership Type _____ Contract extended to (if needed) _____ Refund Due: _____ (\$ or N/A)

Staff Initials _____ Change Entered: _____

X:MEMBER SERVICES\Forms revised 5/5/23

Request for Change in Membership



Duke Center for Living
at Fearington

DukeFitnessFearington.com
100 Clynesh Close
Pittsboro, NC 27312
Phone: 919-545-2133
Fax: 919-545-2687