Duke Center for Living
at Fearrington

100 Clynelish Close • Pittsboro, NC 27312
Phone: 919-545-2133 • Fax: 919-545-2687
DukeFitnessFearrington.com

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 ____**Todays Date**______________

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 for Members in initial Annual Agreement term**

- **May be granted immediately 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: Annual Contract will be charged 2 months of dues for early termination***
☐ ***30-Day Advance Notice on Monthly Contracts****.*

Termination Effective 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.

FOR STAFF USE ONLY
Membership Type _____________________Contract extended to *(if needed)* ________ Refund Due:________ ($ or N/A)
Staff Initials ________ Date Change Entered: __________ *X:\MEMBER SERVICES\Forms* *revised 9/12/23*

Member Signature ____ **Date** ____________

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