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** _____

Type of Membership Change Requested (Please check one):

___ **VACATION FREEZE** ☐ **EARLY RETURN** _____

- *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** ☐ **EARLY RETURN** _____

- *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** **Paperwork Attached**_____ **(Y or N)**

- ☐ ***30-Day Advance Notice***.
- ☐ ***Other members on Agreement need to be re-written***

- **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 with proof of address of relocation of 50 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.*

Termination Effective Date: _____ **Reason** _____
(TO BE OUT BY DCFL STAFF)

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 STAFF USE ONLY Membership Type _____ # GP Adj._____ Date Change Entered: _____
Refund Due: _____($ or N/A) Charges Due: _____ ($ or N/A) Staff Initials _____

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