

## 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: \_\_\_\_\_

# Medical Freeze



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