

MEMBERSHIP FREEZE REQUEST



SENTARA®

This request is made with the understanding that it will be reviewed and subject to approval based on form policies below.

A frozen member may not access the facility during the freeze period.

RMH Wellness Center
Sentara RMH Wellness Center
2500 Wellness Drive
Harrisonburg, VA 22801
540-564-7197 phone
540-564-5528 fax

PLEASE PRINT CLEARLY all adult members on the account who are requesting frozen status:

Member Name: _____ Member Name: _____

Only the primary and secondary adult member may request a freeze. Children on one parent and family memberships may not use the facility during the freeze period if all guardians are frozen.

Please review and initial all statements of understanding:

- _____ The terms of freeze on this form supersede previous hold terms in the membership agreement.
- _____ To be eligible for a freeze my account must be in good financial standing and all balances paid.
- _____ I may not put my account on freeze until I have completed my initial membership term of one full billing cycle in active status.
- _____ All freeze requests must be in a full month increments for a minimum of 1 month and maximum of 3 in a calendar year.
- _____ My freeze will end on requested end date and my account will automatically reactivate on the 2nd of the month.
- _____ I may not use the facility while my membership is in freeze status.
- _____ If I return before the requested end date the account will be reinstated and pro-rated dues will be charged.
- _____ In order to submit a 30 day membership cancellation, my membership must be in active status. Cancellation fees will apply to include any pro-rated dues charges and one full monthly dues payment.
- _____ If I currently rent a locker, locker rental charges will continue during the freeze status.
- _____ Account holder is responsible for paying a freeze fee (if applicable) and keeping the account on file up to date per membership agreement.

Freeze must be requested before the first of the month of the freeze period.

Start Date: (Must be future date) 1st day of _____, _____
Month Year

MIN: 1 Full Month
MAXIMUM: 3 Full Months
per CALENDAR YEAR

End Date: 1st day of _____, _____
Month Year

MEMBERSHIP WILL AUTOMATICALLY REACTIVATE AND BILLING FOR FULL AMOUNT OF MEMBERSHIP DUES WILL

RESUME ON: 2nd day of _____, _____
Month Year

Member's Signature: _____ Date: _____

Member's Signature: _____ Date: _____
(if applicable)

Type of Freeze Requested: (Check One)

_____ **PERSONAL**- A temporary freeze may be requested for a minimum of (1) month and a maximum of (3) months during a calendar year. Account will be billed at \$15 per adult on freeze per month. If the second adult on the account remains active, dues will continue at the adult, or one parent rate. The account will automatically reactivate at the end of the requested freeze period.

_____ **MEDICAL**- Must include a physician's signature. A freeze will not be activated until this form is received by the membership office, complete with physician's signature. Injury, illness or disability must **prevent the member from participating in physical activities** during the time period requested. Medical freeze may be requested for a minimum of (1) month and a maximum of (3) months during a calendar year. If the second adult on the account remains active, dues will continue at the adult, or one parent rate. Early release from a medical hold will require a note from the doctor stating that resumption of physical activity is approved. A frozen member may not access the facility during the freeze period.

Reason for Medical Hold: _____

Physician's Signature: _____ Date: _____

Office Use:

Received By: _____ Date: _____