



Membership Freeze Request
(Please allow up to 10 business days processing)

Member Name _____ Membership # _____

Address _____
Street _____ Apt/# _____
City _____ State _____ Zip Code _____

Home Phone: _____ Email _____

You will be charged \$ 15 for each month that your membership is frozen in lieu of the standard monthly fee.

Please select months you wish to freeze:

- January February March April May
 June July August September October
 November December

Please state the reason for freeze request (if for medical reasons please provide medical documentation):

Member Signature: _____ Date _____

Staff received: _____ Date _____