

Cancellation after the 5th of month will be billed in full.

CANCELLATION FORM

1. Request for:

Cancellation (\$25 to reactivate membership)

Effective Date: _____

Medical Leave (Doctor's release required to reactivate.)

Please check one of the following below

2. **Please cancel my:** Bank draft with (list bank name) _____

Credit Card/Debit Card

Payroll through (list your employer) _____

3. **Please list all members who require cancellation:**

a. _____ b. _____ c. _____

4. **Reason for cancellation:**

_____ I'm not meeting my goals

_____ Lack of time

_____ Insufficient services

_____ Other _____

5. **What can we do to improve our services?**

6. I understand that I am responsible for many balance on my account through this date.

Client Signature

Date

Client Name

Staff Member Signature

For Office Use Only:

Keyed _____

Credited _____

Draft Canceled _____

Payroll Notified _____

Balance _____