MEDICAL HOLD FORM

MEMBER INFORMATION

MEMBER	Legal First Name	M.I.	Legal Last Name	Birthdate	Gender	Nickname	Primary Phone #

Street Address	City	State	Zip	Email

TO BE COMPLETED BY PHYSICIAN

This will certify that _____ is under my care. To reduce the risk of any complications in this patient's condition, the above patient will be unable to utilize their YMCA membership from ____/____/____ to ____/____/____.

(Patient's Name)

(Hold start date)

(Hold end date)

Physician's Signature: _____ **Date:** ____/____/____

PHYSICIAN INFORMATION

PHYSICIAN	First Name	Last Name	Primary Phone #	Fax #

Street Address	City	State	Zip	Website

I hereby request that my membership at the Grand Traverse Bay YMCA be placed on a Medical Hold. I understand that my membership will be placed on hold for the duration indicated by the physician above, **and that my monthly membership will automatically resume after the above indicated end date.** If my membership is annual, I understand that my membership will be extended the same number of months it is being placed on hold.

Member's Signature: _____ **Date:** ____/____/____