Medical Cancellation Request Procedure

The Medical Cancellation Form is a request for Cancellation. Please complete the top section of the form yourself and have your physician complete the remaining section. Include a check, money order, or credit/debit card number to cover the $25 processing fee as noted on the form.

Please mail the form back to:

BAC/RAC for Women Customer Service

3157 Eggert Road

Tonawanda, NY 14150

Based on the information provided by your doctor, we will determine whether or not your request meets the terms of cancellation per your membership agreement. If not, your membership time will be frozen and your payments will continue. You will receive the frozen time at the end of your current term or if you are in "rollover" status when you are ready to resume your membership.

You will be notified within two weeks of receipt of your request whether or not your membership will be cancelled or frozen.

BAC/RAC for Women Customer
3157 Eggert Road
Tonawanda, NY 14150
Phone 716-370-0677 / 844-808-8790

Patient's Name_____ **Date of Birth**_____ **Date of Request**_____

I authorize Dr._____ to release information to the BAC / RAC for Women Athletic Club for the purpose of determining safe participation in an exercise program, which may consist of cardiovascular exercise, resistance training, stretching, and other forms of physical activity at the club.

The **significant physical disability** that I feel needs to be addressed for the sole purpose of cancelling membership contract to the health club that I currently belong to is _____.

This authorization is valid for this request and any future treatment of the conditions described above until cancelled by the patient. Per the physician's instructions, the patient may cancel this authorization at any time. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the club and is no longer protected by HIPAA.

Patient Signature _____

****THE FOLLOWING INFORMATION IS TO BE PROVIDED BY A PHYSICIAN ONLY****

1. Diagnosis of injury / illness _____

2. This patient has been under my care since_____

3. Is there a **significant physical disability** that will cause any limitations to the following cardiovascular activities? If yes, what limitations and for what period of time are they prohibited from participating in that type of activity?

Bicycling Y N _____For how long? _____

Walking Y N _____For how long? _____

Stair Climbing Y N _____For how long? _____

Running Y N _____For how long? _____

Elliptical Machines Y N _____For how long? _____

Aerobic Classes Y N _____For how Long? _____

4. Is there **a significant physical disability** that will cause any limitations to weight bearing exercises? Y _____ N _____
If yes, what are the limitations to the following areas and what time period are they prohibited from participating in that type of activity?

Upper Body Movements Y N _____ _____For how long? _____

Lower Body Movements Y N _____ For how long? _____

5. Are there any specific heart rate limitations Y N If yes, what _____

Doctor's recommended treatment and continued use of the facilities_____

_____

_____

Physician's Name (Please print) : _____

Physician's telephone #_____ Fax # _____

Authorized Physician's Signature_____ **Date Signed** _____

Please submit completed form to the BAC / RAC for Women Athletic Club along with your membership card, and a $25.00 payment for cancellation / processing fee. You may submit this payment in the form **of** a personal check, money order or credit card

Credit Card # _____-_____-_____-_____ **Exp. Date:** _____