Customer Service Department
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Tonawanda, NY 14150
Ph: 716-370-0677
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REQUEST FOR A TEMPORARY MEDICAL MEMBERSHIP FREEZE

Date: _____ Patient's/Member's Name: _____ Barcode ID #: _____

Diagnosis of injury/illness: _____

Recommended Treatment: _____Date of Surgery (if applicable) _____

Please indicate with a check mark the activities the patient is able to participate in:

__Bicycling
__Stair climbing
__Jogging
__Rowing
__Cross country skiing
__Spinning class's
__Upper body weights
__Lower body weights
__Lifting above the head
__Dry sauna
__Steam Room
__Aerobic

Are there any heart rate limitations? ____If yes, rate should not exceed_____

Is there anything specific to avoid? _____

SPECIFY DATES PATIENT IS UNABLE TO EXERCISE AND ABLE TO RESUME EXERCISE:

Attending Physician's Name: _____
(Please print)
Address: _____
(City) (State) (Zip)

Phone Number :(____) _____ Date: _____

Physician's Signature: _____

MEMBER: Please be advised that the monthly payments of your membership dues will continue as scheduled. Membership time will not be frozen until the completed freeze form is received in our office. Medical freezes will not be backdated. The minimum amount of freeze will be one month, but not greater than 12 months.

Member's Signature: _____ Date: _____-

Please indicate if you currently have monthly deductions for a personal training account by checking yes or no.

Personal Training Account: YES:_____ NO:_____.