

# CANCELLATION FORM

Name \_\_\_\_\_ Account # \_\_\_\_\_

Phone \_\_\_\_\_ HP Staff \_\_\_\_\_

Additional Family Members \_\_\_\_\_

Cancellation Request (30-day notice needed for cancellation)

Reason: \_\_\_\_\_

**Overall I was:**

Pleased with my membership

Displeased with membership

**Healthplex Medical Fitness Center Cancellation Policy**

Healthplex Fitness Center requires a 30 day notice of our member's cancellation request. By signing the request to cancel your membership below, you understand our cancellation policy and will adhere to our policy.

Member's Signature \_\_\_\_\_ Date \_\_\_\_\_

Suggestions for improvements or comments about the program:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Office Use Only:** Transaction completed \_\_\_\_\_  
Date sent to payroll \_\_\_\_\_

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