

**MEMBERSHIP
 FREEZE FORM**
 (Must be completed 15 days
 prior to effective freeze)

Name _____ Date: _____
 Member # _____ HP Staff _____
 Phone _____
 Freeze Month(s): 1. _____ 2. _____ 3. _____
Maximum of 3 months

REASON:

- Medical: _____
- Vacation: _____
- Other: _____

Family Members included in the freeze: _____

FEE:	# months	For office use only
<input type="checkbox"/> \$5.00 per member per month _____		Payment method: <input type="checkbox"/> Cash <input type="checkbox"/> Account <input type="checkbox"/> Debit <input type="checkbox"/> EFT <input type="checkbox"/> Charge _____ (Visa, MC, etc)
<input type="checkbox"/> \$10.00 per family per month _____		
Total due \$ _____		
Fee due upon receipt of request.		

PLEASE NOTE:

- After the freeze date is up, your membership will automatically be reactivated.
- Medical holds require a doctor's release upon return.
- Comments: _____

Member's Signature _____ Date _____

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