

# Dexter Wellness Center

## Membership Bridge/ Medical Freeze Request



### General Information

Member(s) Name*	Date		
Member ID	Membership Type		
Address	City	State	Zip
Email Address*	Phone*		

\*Required fields

### Request Details

(Choose **Bridge** or **Medical Freeze** and mark as applicable; refer to the [Membership Bridge/Medical Freeze Policy](#) document for guidelines)

Requested Start Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Requested End Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

- Optional Bridge:**     Member(s) Listed Above Only     Entire Membership
- Medical Freeze:**     Member(s) Listed Above Only     Entire Membership
- Relocation Bridge:**     Member(s) Listed Above Only     Entire Membership

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

*By signing below you acknowledge that you have read and agree to the terms and conditions within the Membership Bridge/Medical Freeze Policy. Any adjustments to account billing will begin once your bridge/freeze becomes effective or with the first billing cycle after approval based on the timing of your request.*

\_\_\_\_\_ *Member Initials – I understand during my bridge/freeze I shall not have access to the Center except for community events open to members and non-members (Exception: Members on a Bridge may purchase a Bridge Day Pass to use the facility). I also understand at the conclusion of my bridge/freeze dues adjustments, membership charges/billing will resume. Refunds or credits will not be provided for dues already collected if cancellation is submitted during an approved bridge.*

Member Signature \_\_\_\_\_ Date \_\_\_\_\_

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

### For Office Use Only

Approved     Not Approved    # Months Approved \_\_\_\_\_    # Additional Days Approved \_\_\_\_\_  
(Medical Freeze Only)

Billing Adjustments Begin \_\_\_\_\_ Billing Adjustments End \_\_\_\_\_

Total Monthly Dues \_\_\_\_\_

Yearly Expiration Extension: From \_\_\_\_ / \_\_\_\_ / \_\_\_\_ To \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Comments \_\_\_\_\_

Accounting Staff Signature \_\_\_\_\_ Date \_\_\_\_\_

Return completed form to Kathy Kahler [kkahler@powerwellness.com](mailto:kkahler@powerwellness.com)