Dexter Wellness Center

# Membership Bridge/ Medical Freeze Request

## General Information

Member(s) Name* Name Here  Date 0/0/2022

Member ID Member ID  Membership Type Membership Type

Address Address  City City  State MI  Zip 000000

Email Address* youremail@domain.com  Phone* 000-000-000

**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 00 / 00 / 2022  Requested End Date 00 / 00 / 2022

☐ **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 Address  City City  State MI  Zip 000000

*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 Name Here  Date 0/0/2022

Employee Signature Name Here  Date 0/0/2022

## For Office Use Only

☐ Approved ☐ Not Approved  # Months Approved 000  # Additional Days Approved 000 *(Medical Freeze Only)*

Billing Adjustments Begin 00/00/2022  Billing Adjustments End 00/00/2022

Total Monthly Dues $000

Yearly Expiration Extension: From 00 / 00 / 2022  To 00 / 00 / 2022

Comments Comments start here

Accounting Staff Signature Staff Name  Date 00/00/2022

**Return completed form to Kathy Kahler kkahler@powerwellness.com**