Medical Suspension Request Form

COCKBURN ARC

PERSONAL DETAILS	
First name:	Surname:
Mobile:	Email:

ACKNOWLEDGMENT OF TERMS AND CONDITIONS

- ☐ I acknowledge by signing this suspension request form I have read and understood the following terms and conditions;
- ☐ I acknowledge that it may take 5 business days' to process my suspension.
- ☐ I acknowledge that I can suspend my membership a maximum of 84 days' per calendar year unless a valid medical certificate is supplied.
- ☐ Membership payments will not be taken for the days that I have suspended, a prorate amount for the fortnight leaving and returning will be deducted.
- ☐ Suspension forms lodged within 5 days notice of the next direct debit date will be reflected in the following fortnights direct debit.
- ☐ Suspensions are for a minimum 7 day period.

Customer Signature:	Date:

MEDICAL CERTIFICATE

It has been my opinion this person is/has been unfit for: ☐ work/study ☐ exercise ☐ swimming

from ___/___/______ to ___/___/______

It is in my opinion this person requires care full time during this period: ☐ Yes: By ____________________

☐ No

CERTIFICATION BY MEDICAL PRACTITIONER

Printed Name:	Date:
Medical Centre Name:	Signature:
Contact number:	

Staff Acceptance:	Date:
Actioned by:	Date:

Cockburn ARC, 31 Veterans Parade, Cockburn Central, 6164 Phone: (08) 9411 3344 Email: info@cockburnarc.com.au

COCKBURN ARC

Medical Cancellation Request Form

PERSONAL DETAILS	
First name:	Surname:
Mobile:	Email:
Are there any other family members that need to cancel their membership? YES / NO (please circle)	

CANCELLATION DATE
☐ I wish to cancel my membership as of todays date: ___/___/______

ACKNOWLEDGMENT OF TERMS AND CONDITIONS	
☐ I acknowledge that my membership type/rate may not be available if I wish to join Cockburn ARC in the future. ☐ I understand all outstanding amounts must be paid in full. ☐ I acknowledge I will be required to provide 28 days' notice and pay a $49 early exit fee (if applicable) if the medical certificate below is **not** completed in full by a medical practitioner.	
Customer Signature:	Date:

MEDICAL CERTIFICATE
It has been my opinion this person is/has been unfit for: ☐ work/study ☐ exercise /swimming from ___/___/______ for three (3) months or more.
It is in my opinion this person requires care full time during this period: ☐ Yes: By ____________________ ☐ No

CERTIFICATION BY MEDICAL PRACTITIONER	
Printed Name:	Date:
Medical Centre Name:	Signature:
Contact number:	

Staff Acceptance:	Date:
Actioned by:	Date: