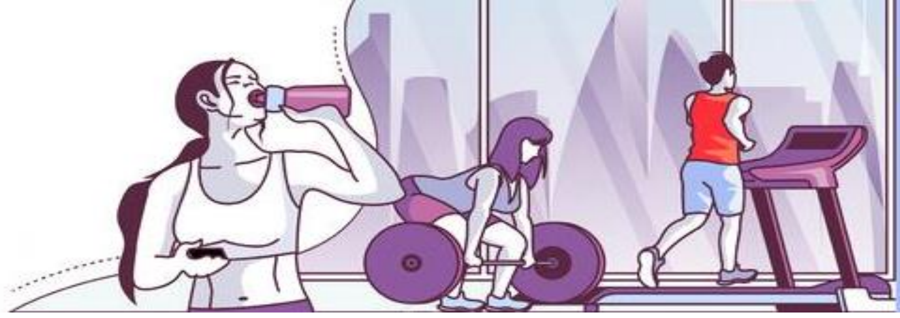
Membership Cancellation Form



MEMBER DETAILS

Name: ____ Member Number: ____________

Address:____

DOB: _____ / _____ / _____ Mobile: ____________________ Home Phone: ______________

Email: ____

CANCELLATION DETAILS

Date of Cancellation: ________ / ________ / ________

Last Day of Membership: ________ / ________ / ________

(Note: The last day of membership shall be calculated to take into account a notice period of 4 weeks from receipt of the written cancellation notice).

REASON FOR CANCELLATION

☐ MEDICAL ☐ RELOCATION ☐ NON-USAGE ☐ OTHER (DETAIL BELOW)

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____

SIGNATURE

Member Signature: ____________________________________ Date: ______ / ______ / ______

OFFICE USE ONLY

Date Received: ________ / ________ / ________ Staff Member Signature: ____________________________

Date Actioned: ________ / ________ / ________ Staff Member Signature: ____________________________