

Chelsea 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 jhoward@powerwellness.com