



Cancellation Form

Today's Date: _____ Membership End Date: _____

UF Health Shands Fitness and Wellness Center Cancellation Policy:

- A \$100 cancellation fee will apply to all memberships
- Cancellation must be in writing 30 days in advance of cancellation date

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Name: _____

Address: _____

Phone Number: _____ Email: _____

Reason for Membership Cancellation (*Please choose ONE*):

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> Crowded | <input type="checkbox"/> Lack of Use |
| <input type="checkbox"/> Distance | <input type="checkbox"/> Cost |
| <input type="checkbox"/> Health Reasons | <input type="checkbox"/> Moving |
| <input type="checkbox"/> Traveling | |
| <input type="checkbox"/> Joined another fitness center (<i>Name of fitness center</i>): _____ | |

PAYMENT: Payroll Deduction Check Credit Card Amount: \$100.00

Check #: _____ Credit Card Auth. #: _____

Signature: _____ Date: _____

Staff Signature: _____ Date: _____