Verification of Disability

Mail to:
Richmond Fitness
ATTN: VOD
4200 Innslake Drive, Suite 104
Glen Allen, VA 23060
or Cancel@amfamfit.com or fax 804.217.7871

TO BE COMPLETED BY THE MEMBER

*MEMBER NAME:	*MEMBER NUMBER/BARCODE:
*E-MAIL ADDRESS:	*PHONE NUMBER:

*Mandatory fields. Additional information may be requested at the discretion of the facility.

I wish to: □ Freeze my membership □ Cancel my membership
I understand that this form needs to be accompanied with either a freeze or cancellation form to complete the action.

TO BE COMPLETED BY THE LICENSED MEDICAL PROFESSIONAL

Your patient is requesting to alter their legally binding contract with American Family Fitness due to a physical disability. Please complete the required fields below in regard to the disability.

My patient has a condition that: (check one)

- ☐ Does not allow my patient to utilize a health club under any circumstances or in any way for a period of at least 30 consecutive days.
- ☐ Would not affect health club use.

The duration of this condition: (check one)

- ☐ Ended on : _____
- ☐ Still persists, and will last for _____months, _____years.
- ☐ Still persists and will be permanent.

The person listed above is my patient and is under my care. I certify that the patient has been found to have a disability that will not allow the patient to use a substantial portion of the services offered by American Family Fitness. This condition has been confirmed through thorough physical examinations and appropriate testing. I will make myself available for any necessary court testimony, with competent jurisdiction, to verify the above patient's condition is stated truthfully. I understand that any costs associated with the testimony will be the patient's responsibility. **I also understand that if any of the above representations are found to be untrue that I could be found liable for damages and prosecuted to the full extent of the law.**

_____ _____
Licensed Medical Professional, signature Date

_____ _____
Licensed Medical Professional, printed Medical License Number (Required)

_____
Licensed Medical Professional's Phone Number