PERMANENT INCAPACITY OR LONG TERM INCAPACITY DECLARATION

Member's Name: _____

Member No: _____

Address: _____

Home Club: _____

This form is to be completed by a registered medical practitioner. This includes General Practitioners, surgeons and specialists but does not include allied health professionals such as nurses, physiotherapists, acupuncturists, chiropractors or other providers of complementary medicine or therapy. An original medical certificate on the medical practitioner's letterhead must be attached to this form in support of this application.

On joining Fernwood Women's Health Clubs, members enter into a contract to complete an agreed term of membership or pay a cancellation fee. Under the terms and conditions of membership, Fernwood enables members to defer their membership for a period of time as specified on their Membership Agreement.

Members may also cancel their membership if they suffer permanent physical incapacity or long term physical incapacity. Long term physical incapacity is defined as an injury or ailment which prohibits the individual from participating in any kind of physical activity offered by the club for a period of not less than 12 months.

We understand that sometimes exercise may be limited or not recommended for a longer term than our deferral privileges allow and we will consider a longer term suspension or cancellation in accordance with our terms and conditions upon receipt of this completed declaration and a medical certificate from you.

With your patient's consent, please complete the following questions. Tick the box or boxes of the option/s applicable to the member and enclose an original medical certificate on your practice/clinic letterhead.

The Medical Condition: _____

This Condition precludes this member from all exercise for a period of:

☐ Up to 3 months ☐ 3 to 6 months ☐ up to 9 months ☐ 12 months or more

I therefore recommend this member be accepted for the following special membership consideration:

☐ Deferral: Rest from all activity for a period of up to _____ months

☐ Cancellation. This member cannot undertake any reasonable exercise regime (ie: walking, cycling, yoga) for a period longer than 12 months. (please provide any other details that may assist this member in this application)

An original medical certificate on the medical practitioner's letterhead must be attached to this form in support of this application.

Medical Practitioner's Stamp

Medical Practitioners Name _____ **Signature** _____ **Date** _____

Thank you for taking the time to assist our member by completing this Declaration.

FITNESS fernwood