

# Verification of Disability



Mail to:  
Richmond Fitness  
ATTN: VOD  
4200 Innslake Drive, Suite 104  
Glen Allen, VA 23060  
or [Cancel@amfamfit.com](mailto: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