

MEMBER DETAILS

Membership #:		Signature:	Date:
Mr/Mrs/Ms/Miss	Full Name:		DOB:
Address:			Postcode:
Email:			Phone:

CANCELLATION REASON

We're aiming for continual improvement and your feedback can help us with this. Please tell us why you wish to cancel your membership. Your comments are appreciated.

Moving out of the area <input type="checkbox"/>	Not a financial priority <input type="checkbox"/>	Work/Family Commitments <input type="checkbox"/>	Medical reasons <input type="checkbox"/>
Changing to another facility <input type="checkbox"/>	I'm not motivated to use my membership <input type="checkbox"/>	I'm dissatisfied with my membership* <input type="checkbox"/>	Other* <input type="checkbox"/>

* Please provide additional information:

Would you recommend SWSC to friends/family?

Yes

No

**PLEASE NOTE: 14 DAYS NOTIFICATION PRIOR TO THE REQUIRED CANCELLATION DATE MUST BE PROVIDED.
CANCELLATION IS NOT COMPLETE UNTIL RECEIPT OF NOTICE VIA EMAIL FROM SWSC.**

OFFICE USE ONLY

Membership Type:		Cancellation Date:	
Upfront refunds will only be approved with a medical certificate. No other reason is valid.			
Cancellation:			
Within 7 day cooling off period <input type="checkbox"/>	Transfer - \$25 <input type="checkbox"/>	14 days notice given <input type="checkbox"/>	
Receipt of payment:		Staff Initials:	
Amendments required:			
Supervisor Approval:			Date:
Action taken by Membership Consultant:		Audit by second Membership Consultant:	
Database changed to cancel <input type="checkbox"/>		Database changed to cancel <input type="checkbox"/>	
Refund required	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Refund application to council completed <input type="checkbox"/>
Membership Consultant Processing Cancellation:			Date: