Staff _____

DOW BAY AREA FAMILY YMCA

MEDICAL HOLD

Date: _____ Member Number: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

TO BE COMPLETED BY YOUR MEDICAL PRACTITIONER

This will certify that _____ is under my care. To reduce the risk
(Patient Name)

of any complications in this patient's condition, the above patient will be unable to utilize their YMCA membership from _____ to _____
(Definite Start Date) (Definite End Date)

Medical Practitioner's Signature: _____ Date: _____

MEDICAL PRACTITIONER CONTACT INFORMATION

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax #: _____

Medical hold up to 6 months per year at $0

Signature: _____ Date: _____

OFFICE USE ONLY

Completed By: _____

Revised: 3/13/23