HALLETT CENTER
of Crosby

REQUEST FOR CANCELLATION

30 days written notice is required. You have access to the facility for the entirety of your last billing month.

Member Name:_____

Phone Number:_____

Names of Members on Account:_____

_____

_____

Reason for Resignation:

Relocation Cost Medical Convenience

Facility Offerings Facility Policies

Other:_____

Today's date:_____

Date resignation will be effective:_____

_____ _____

Member Signature Date

_____ _____

HCC Associate Signature Date

OFFICE USE ONLY

_____ _____

Date Entered Book Keeper's Initials