

**EMORY
DECATUR
HOSPITAL**

Emory Decatur Hospital Wellness Center
2665 North Decatur Road, Suite 10
Decatur, Georgia 30033

Cancellation Form

I understand that 30 days notice is required for cancellation of membership.

Please Print:

Member name _____ Member Type _____

Address _____ City _____ State _____ Zip _____

New Address? Yes No Phone # _____ Email Address _____

Reason for Cancellation

Relocation Military Deployment Medical Location of Facility Lack of Use

Financial Hardship Facility Too Crowded Joined Another Facility

Additional Reasons (please explain)

How likely would you be to recommend the Wellness Center to a friend?

0 1 2 3 4 5 6 7 8 9 10
Not Likely Very Likely

Please share any suggestions you have for improving your Wellness Center:

Member Signature _____ Date _____

Staff Signature _____ Date _____

Office Use Only:

Date Received: _____

Staff Signature: _____