CYC Membership Cancellation Form

MEMBER INFORMATION

I understand that my cancellation request must be received 15 days prior to the end of the month in order for my payment to cease for the next scheduled month.

Member Name (first, middle, last): _____

Primary Contact Name: _____

Address: _____ City: _____ Zip: _____

Email: _____ Phone: _____

What made you decide to cancel your Membership?

_____

_____

_____

Which program(s) was the Member enrolled in?

- ☐ Academic Excellence
- ☐ Boxing
- ☐ Cheer
- ☐ Wrestling
- ☐ Dance
- ☐ Gymnastics
- ☐ Judo
- ☐ Competitive Team
- ☐ Soccer
- ☐ Sport Specific
- ☐ Taekwondo

Would you consider returning to CYC in the future? Yes ☐ No ☐

We appreciate any feedback, CYC story, staff recognition or sharing ideas you may have:

_____

_____

_____

_____

_____

Primary Signature: _____ Date: _____

Printed Name: _____ Relationship to Member: _____

OFFICE USE ONLY

Date Received by CYC Front Office: _____ Name: _____

Membership is paid current: Yes ☐ No ☐ If no, amount due: _____

Scholarship Member: Yes ☐ No ☐

Last Day of CYC Program(s): _____ Primary Initials: _____

Approved by Supervisor: _____ Signature: _____