



Rockport Country Club

RCC MEDICAL LEAVE OF ABSENCE REQUEST FORM

NAME OF MEMBER: _____ MEMBER NUMBER: _____

MEDICAL CONDITION PREVENTING PLAYING GOLF OR TENNIS:

NAME OF MEDICAL DOCTOR PROVIDING ATTACHED LETTER:

BEGINNING DATE OF INTENDED MEDICAL LEAVE:

INTENDED ENDING DATE OF MEDICAL LEAVE:

NOTE: BY MY SIGNATURE BELOW, I _____,
HEREBY REQUEST A MEDICAL LEAVE OF ABSENCE FOR THE DATES
SHOWN ABOVE. I ACKNOWLEDGE THAT IF THE REQUEST IS
GRANTED, I AND ALL OTHERS THAT HAVE CLUB PRIVILEGES
PURSUANT TO MY MEMBERSHIP ARE ENTITLED TO USE THE CLUB
FACILITIES TO THE SAME EXTENT AS ASSOCIATE MEMBERS EXCEPT
THERE WILL BE NO ACCESS TO THE GOLF COURSE, THE DRIVING
RANGE OR TENNIS COURTS. I WILL BE REQUIRED TO PAY ONE-THIRD
(1/3) OF THE REGULAR RESIDENT MEMBERSHIP MONTHLY DUES AND
WILL BE RESPONSIBLE FOR ALL OTHER REQUIRED CLUB FINANCIAL
PAYMENTS.

SIGNED: _____ DATED:

ACTION BY MEMBERSHIP AND BY-LAW COMMITTEE:

BY: _____

DATED: _____