**VISIT CANCELLATION FORM**

We require 14 days cancellation notice prior to your scheduled care visit date without charge.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date** | **Time** | **Caregiver** | **Cancellation Shift** | **Cancellation Hours** | **Cancellation %** | **Cancellation Charge** | **Care Pro Name** | **Care Pro Notified** |
|  |  |  |  |  | □10% 14 to 8 days prior  □30% 7 to 3 days prior  □50% 2 days prior  □70% 1 day prior  □100% |  |  | □Yes □No |
|  |  |  |  |  | □10% 14 to 8 days prior  □30% 7 to 3 days prior  □50% 2 days prior  □70% 1 day prior  □100% |  |  | □Yes □No |
|  |  |  |  |  | □10% 14 to 8 days prior  □30% 7 to 3 days prior  □50% 2 days prior  □70% 1 day prior  □100% |  |  | □Yes □No |
|  |  |  |  |  | □10% 14 to 8 days prior  □30% 7 to 3 days prior  □50% 2 days prior  □70% 1 day prior  □100% |  |  | □Yes □No |