



CMU HEALTH
CENTRAL MICHIGAN UNIVERSITY

Attendance Agreement

I acknowledge, as a patient of CMU Health, that my attendance to scheduled appointments is important to my healthcare. I understand that CMU Health has an Attendance Policy, and that if I miss multiple appointments OR cancel an appointment the same day, I may be dismissed as a patient of CMU Health.

Date: _____

Patient Name (print): _____

Patient Signature: _____

Parent/Guardian Name (print): _____

Parent/Guardian Signature: _____