

## Physician's Clearance to Exercise

Dear Dr. \_\_\_\_\_

Date: \_\_\_\_\_

Patient: \_\_\_\_\_

D.O.B. \_\_\_\_\_

Your patient is interested in participating in fitness activities at the LECOM Medical Fitness & Wellness Center. We strongly recommend that all of our members undergo a **Health & Fitness Assessment**, which may include:

- Sub-maximal treadmill/walking tests (various protocols)
- Muscular strength/endurance evaluations (upper body, lower body and/or abdominal)
- Flexibility test
- Body composition measurements

Due to the identification of risk factors from the participant's Health History Questionnaire, we require your approval before the exercise program can be initiated.

I hereby grant LECOM Medical Fitness & Wellness Center permission to request physician approval for me to exercise. I understand this is for my safety and benefit.

**Member Signature:** \_\_\_\_\_

Members may not use this facility until this form is completed. Thank you for your cooperation in this matter. Please check the appropriate box.

- I **fully approve** of this patient's participation in fitness activities **without limitations** based on satisfactory completion of the intake process.
- I **conditionally approve** of this patient's participation in fitness activities with the recommendations and/or restrictions listed below.
- I **do not approve** of this patient's participation in fitness activities at this time. **(If checked, individual will not be accepted until further notice from your office).**

**Please complete and fax back to (814) 868-7804 at your earliest convenience.**

### RECOMMENDATIONS/RESTRICTIONS

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**Physician's Name (Please Print):** \_\_\_\_\_

**Physician's Signature:** \_\_\_\_\_

For staff use:      **Requesting Approval:**    Fax to Drs Office \_\_\_\_    Log it \_\_\_\_    File it \_\_\_\_

**Returned Approval:**    Copy to Customer S \_\_\_\_    Log it \_\_\_\_    Call to set up FC \_\_\_\_    File in member chart \_\_\_\_