❑ **New Member**
❑ **Past or Returning Member**

Wellness Center Medical Clearance

Dear Doctor _____,

_____ _____ _____
(Name) (Phone #) (DOB)
wishes to take part in an exercise/fitness program. The exercise program may include progressive resistance training, flexibility exercises, and a cardiovascular program; increasing in duration and intensity over time.

By completing this form, you are not assuming any responsibility for our exercise and assessment program. Please identify any recommendations or restrictions for your patient's fitness program below.

❑ I am not aware of any contraindications toward participation in a fitness program.
❑ I believe the applicant can participate, but I urge caution because: _____
_____
_____

❑ The applicant should **not** engage in the following activities: _____
_____
_____

❑ I recommend the applicant **not** participate in the above fitness program.

❑ If your patient is taking medications that will affect their response to exercise, please indicate the manner of the effect. Type of medication: _____
_____

Physician's Signature: _____ Date: _____

Physician's Name (Please Print): _____ Phone: _____

*Please direct any questions to:

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