Woman's Center for Wellness

Medical Exercise Physician's Clearance

Dear Dr.,

Your patient, ___________________________________; (DOB ______/______/______) is interested in taking part in a supervised exercise program that we currently offer. He/She is interested in participating in the ____________________ exercise sessions. The Wellness Center's Medical Exercise Program is designed to provide an environment for your patient to participate in safe and effective exercise, individualized to meet your patient's needs. This program is ideal for the following types of patients: recent discharge from therapy, multiple diseases and/or health conditions, deconditioned, new to exercise, or require more individualized instruction and supervision than provided in a traditional fitness club setting. The exercise sessions are coordinated by an ACSM certified exercise physiologist with a special interest in wellness.

Your patient has completed a medical history questionnaire and has been screened by an exercise physiologist. By completing this form, you are not assuming any responsibility for our screening process. If you know of any reason why your patient should not participate in our supervised exercise program please indicate the reason below.

Thank you for your assistance.

Patient: ____

- ☐ I know of no reason why the applicant may not participate
- ☐ I believe the applicant can participate, but I urge caution because: ____

  ____

  ____
- ☐ The applicant should not engage in the following activities: ____

  ____

  ____
- ☐ I recommend that the applicant NOT participate.
- ☐ I would like additional information about the Woman's Wellness Center Medical Exercise Programs.

Signature: ____ Telephone: ____________________________________

Address: ____

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WH 7490-2486 (05/14) #0008685