

### Physician Authorization to Participate

Please have your physician sign and date the appropriate section(s).

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

1. This individual has no known contradictions to participate in all fitness programs. Individual may participate in all programs.

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

2. This individual has some limitations, which will restrict full participation in all programs. Individual may participate with the following limitations: (please state limitations) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

3. This individual currently requires a clinically supervised program and will require further medical clearance to participate.

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_