

Physician's Clearance

Individual information requested for (patient's name): _____

Physician's name: _____

Physician's telephone: _____

Physician's fax: _____

Please indicate your recommendation for your patient regarding commencement of increased physical activity.

1. _____ My patient may participate in any activities without restrictions.

2. _____ My patient may participate in any activities with the following restrictions:

3. _____ I do not recommend that my patient participates in any activities at this time.

Physician's signature: _____ Date signed: _____

Return form to: _____

Phone: _____ Fax: _____