

Dear _____:

Your patient, _____ (patient name), wishes to participate in a physical activity and training program. Your patient's current goals and proposed physical activity plan are as follows (to be completed by patient):

Please list any restrictions that you would recommend for this program (to be completed by physician):

Physical limitations: _____

Medications: _____

Other restrictions: _____

_____ (patient name) has my approval to participate in this physical activity and training program with the restrictions described above.

Physician's Signature: _____ **Date:** _____
(to be updated annually)

Participant - Please return completed form at your next program participation, or mail or fax to:

_____ (name/company)

_____ (addr)

_____ (addr)

_____ (fax #)