

PHYSICIANS APPROVAL FORM



Exercise/Fitness & Wellness

_____ has medical approval to participate in exercise/fitness programs at sites including but not necessarily limited to home, office or studio/gym, which may be provided by and/or recommended by Joe Green.

Date of Birth: _____ Last Four Digits of SS#: _____

The Following Restrictions Apply (*if none, so state*):

Physician's Signature

Physician's Name

Street Address

City

State

Zip

Phone

Date

___ Please attach a copy of any notes/recommendations for this person's participation in a home-based clinical exercise program.

(This form may be faxed back to the number listed below!)

Thank you!

FIT FOR YOU Personal Fitness Coaching – Phone: (717) 579-8257 Fax: (717) 545-2595

WEBSITE: WWW.PHYT4U.COM ~ Exercise/Wellness/Nutrition Programs