SharonFrazier

R E S T O R A T I V E F U S I O N ™

PHYSICIAN CLEARANCE FORM Date: ____________

Dear Dr.___________________________:

Your patient ____
(applicant's name)
wishes to participate in Movement Therapy & a full-body multi-functional fitness program of safe exercise.
The purpose of the program is to train the cardiovascular system, condition the muscles and maintain lean body mass with flexibility. Exercises may include:

- Aerobic activities: walking/running, stair climbing, bicycle riding, rowing
- Resistance training: calisthenics, free weights, stretch bands, machines
- Flexibility exercises: range of motion, neuromuscular facilitation and stretching

Please check one:

_______ I find the applicant physically capable of participating in the program as described here.
_______ I find the applicant physically unfit to participate in the program.
_______ I find the applicant limited in exercise capability, but this will not prevent her from joining the program. I recommend the following guidelines and restrictions:

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____

Please list any medications this patient is taking that may affect heart rate, blood pressure and exercise capacity and what that response would be:

____
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____
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____________________________ ____________________________
(Type or print physician's name) (Physician's signature)

____
(Address)

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