Medical Clearance Form

Date:______________________

Dear Physician:

Your patient:______________________ would like to begin an exercise program at our facility for individuals with Parkinson's disease. We require medical clearance and recommendations concerning participation in a regular exercise program. Please provide the following information and return this form to:

Name: Fitness Center at University Hospitals Avon Health Center

Address: 1997 Healthway Drive, Avon Ohio, 44011

Phone: 440-328-3446 **Fax**: 440-988-6810

Email: Kelly.Kacenjar@uhhospitals.org

Are there specific concerns or conditions our staff should be aware of before this individual engages in regular exercise at our facility? Yes No

If yes, please specify:

Physician/NP/PA signature: ____

Provider's name: ________________________________ **Phone:**_____________

Address: ____

PARTICIPANT RELEASE AUTHORIZATION

I hereby authorize release of medical information pertinent to restrictions for my exercise program as determined necessary by my healthcare provider.

PARTICIPANT SIGNATURE DATE