Physician's Approval Form

Please complete this form and return via Fax to the Wellness Research Center at the University of Central Florida (407) 823-0372.

______________________________ has medical approval to participate in fitness programs and in the use of exercise equipment at various sites, including home or office, that may be provided by and/or recommended by the staff of the Wellness Research Center at the University of Central Florida.

Choose the appropriate recommendation for your Patient.

____ Patient is cleared to exercise without restriction.

____ Patient is cleared to exercise with the following restrictions or guidelines. Please include the exercise heart rate and/or MET level desired for you patient. If graded exercise test was performed, please include results if available.

_____ Patient is **not** cleared to exercise.

Physician Signature:____

Physician Name (Print):____

Date:____

Address:____

Phone:____

Fax:____

Email:____

Updated 1-16-03