Dear Doctor,

Your patient, _____, has indicated that you are his/her physician. This individual seeks to begin a moderate to vigorous intensity exercise program under the supervision of a certified personal trainer. Please provide your recommendation regarding exercise participation for this individual and any restrictions and/or limitations you suggest for his/her program. Should you have any questions or concerns, please contact me at the number or email below. Thank you.

Physician recommendation:

- ☐ Patient may participate in unrestricted activity.
- ☐ Patient may participate in light to moderate activities only.
- ☐ Patient should not participate in any activity at this time.
- ☐ Other, please specify: _____

  _____

Please specify any restrictions or limitations you feel are appropriate: _____

_____

Please indicate the date that this clearance will expire: _____

Physician Name: _____ Date: _____

Physician Telephone Number and/or Email Address: _____

Physician Signature: _____ Date: _____

_____

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