



PHYSICIAN CLEARANCE

Dear Dr. _____

Your patient, _____, has expressed an interest in starting a program that includes exercise, meal planning, and nutrition education-under the guidance of the licensed dietitian/nutritionist and certified personal trainer. The exercise portion of the program includes: fitness assessment, including body composition assessment, muscular endurance and flexibility tests, a blood pressure reading, and cardiovascular fitness assessment; and an exercise program, which will include, but not be limited to, progressive resistance training. The sessions will last approximately 1 hour and will begin at a very moderate, submaximal level.

Below is a clearance form to be filled out and signed by you and returned to FIT WITH Z. If you have any question, please feel free to call us at 217-417-0957.

We have applied the standards of the National Strength and Conditioning Association in determining the need for your patient to obtain your clearance so that he/she may participate in our program. Specifically, your patient has been referred to you due to:

- Current or past cardiovascular/cardiopulmonary/coronary heart disease
- High blood pressure
- Diabetes
- Heart/Chest pain
- Fainting or dizziness
- Other _____

Please complete this clearance form, indicating any exercise limitations or recommendations you may have discussed with your patient and which you and your patient agree to disclose to the personal trainer/registered dietitian/nutritionist.

Please complete the form and mail to:

Fit With Z
2005 Vawter Street
Urbana, IL 61801

My patient, _____, has been examined by me and **DOES** have my approval to participate in progressive exercise, meal planning, and nutrition education program. I understand the physical and physiological stressors of the program and see no reason why the above named person should not participate.

My patient, _____, has been examined by me and **DOES NOT** have my approval to participate in a progressive resistance program. (If this statement is filled out, the patient will not be admitted into the program.)

M.D. _____
DATE _____

Please stamp or print Name/Address/Phone

PHYSICIAN'S RECOMMENDATIONS/CONTRADICTIONS

