Medical Clearance

Dear Doctor:

Your patient _____ wishes to take part in an exercise program and/or fitness assessment. The exercise program may include progressive resistance training, flexibility exercises, and a cardiovascular program; increasing in duration and intensity over time. The fitness assessment may include a sub-maximal cardiovascular fitness test and measurements of body composition, flexibility, and muscular strength and endurance.

After completing a readiness questionnaire and discussing their medical condition(s) we agreed to seek your advise in setting limitations to their program. By completing this form, you are not assuming any responsibility for our exercise and assessment program. Please identify any recommendations or restrictions for your patient's fitness program below (Physician's Recommendations).

Patient's Consent and Authorization

I consent to and authorize _____ to release to AMPLIFY FITNESS INC, health information concerning my ability to participate in an exercise program and/or fitness assessment. I understand this consent is revocable except to the extent action has already been taken. Authorization is not valid beyond one year from date of signature. Further disclosure or release of my health information is prohibited without specific written consent of person to whom it pertains.

_____ _____

Patient/Client Signature date

_____ _____

Personal Trainer Signature date

Physician's Recommendations:

_____ _____

Physician's Signature date