

Physician's Statement & Clearance

Physician's Name _____

Physician's Address _____

City _____

State _____

Zip _____

Physician's Phone _____

Physician's Fax _____

1. Your patient, _____, wishes to begin an exercise program.
The activity will involve the following:

Strength Training Cardiovascular Training Other _____

2. Please check the statement that best reflects your wishes:

I concur with my patient's participation with no restrictions.

I concur with my patient's participation if he/she restricts activities to _____

I do not concur with my patient's participation in this program for the following
reason(s): _____

(If checked, the individual will not be accepted.)

Other: _____

3. If your patient is taking medication(s) that will affect his/her heart rate or blood pressure
response to exercise, please indicate the manner of the effect:

Type of Medication _____

Effect _____

4. Please identify any recommendation(s) that are appropriate for your patient in this exercise
program: _____

Physician's Signature _____

Date _____

I hereby give my physician permission to release any pertinent medical information from my
medical records to my personal trainer, Paul Holubets, CPT. // (512) 363-3637

Patient's Signature _____

Date _____