



PHYSICIAN RELEASE FORM

Please print

Patient Name: _____

Primary Physician Name: _____

Physician Phone: _____ Physician Fax Number (if known): _____

Physician Address: _____
Street City State Zip

For Physician Use Only

Please check ONE of the following:

- Member cleared to exercise without restrictions.
- Member cleared to exercise limited to:

- Member cleared to exercise **within the following guidelines:**
 - Aged predicted heart rate ($220 - \text{age} = \text{max HR}$ (50%-85%).
Indicate percentage _____%
 - Frequency (min: 2 times per week/max: 6 times per week) _____x/per week
 - Duration 15 to 60 minutes: Time _____ - _____ minutes
 - Member is cleared to perform a strength training regimen
(circle one): Yes/No

Physician's Signature: _____ Date: _____