



Physician's Approval

Certified Personal Trainer: _____

Phone Number: _____

_____ has been examined by me and has my approval

Participant's Name

to participate in a progressive exercise program. I understand the physical and physiological stressors of the program and see no reason why the above named person should not participate.

Physician's Signature **M.D.** **Date**

TYPE OF ACTIVITY

INTENSITY

Cardiovascular	_____
Resistance Training	_____
Flexibility	_____
Other	_____

PHYSICIAN'S RECOMMENDATIONS/CONTRADICTIONS

