

PHYSICIAN APPROVAL TO EXERCISE

_____ has my medical approval to participate
(Patient's Full Name)

in an exercise and fitness program designed around decreasing cardiovascular risk factors and education regarding proper physical activity.

The following restrictions should be noted (*if there are NO restrictions, please indicate*):

Patient Phone/Email: _____

Date: _____

Physician Name: _____

Address: _____

City/State/Zip: _____

Physician Signature: _____

Labs Attached (Fasting Lipid Panel and Glucose, previous 12 months)

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| Please Fax to: | First Health Associates (847) 593-3346 ATTN: Tom Jordan, MS, RD |
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First Health Associates, SC
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