
MEDICAL CLEARANCE

Dear Doctor:

Your patient wishes to exercise within the TMCC Fitness Center. THIS IS A MEDICALLY UNSUPERVISED SETTING. Blood pressure and EKG readings are not available, emergency response policy for this facility is a phone call to 911.

Please identify any recommendations or restrictions to exercise that are appropriate and counsel your patient as to these recommendations or restrictions for exercising in a medically unsupervised setting.

I, _____ M.D. state that I understand my patient will be exercising in a medically unsupervised setting, and **I have attached a full clearance or any restrictions and recommendations** and have discussed with my patient any recommendations and restrictions I have pertaining to this type of activity.
I hereby release:

_____ to exercise in the TMCC Fitness Center Activity Program.

Signed: _____

Date: ____/____/____

PHYSICIAN LETTERHEAD AND SIGNATURES REQUIRED FOR VALID MEDICAL CLEARANCE

PATIENT PLEASE READ AND SIGN

I agree that my doctor has discussed any recommendations or restrictions he/she may have pertaining to my participation in a medically unsupervised exercise program. I fully understand and agree to comply with the recommendations and restrictions made by my doctor.

Signed: _____
(Patients Signature)

Date: ____/____/____

MEMBER/PATIENT SIGNATURES REQUIRED FOR VALID MEDICAL CLEARANCE