Your patient _______________________________ (Name of Participant) would like to participate in the exercise/fitness programs at ________________________________ (Facility Name), a non-clinical health/fitness facility that provides a variety of exercise/fitness activities. To comply with pre-activity screening recommendations established by the American College of Sports Medicine, we have all participants complete a brief health history questionnaire. Based on the responses, your patient needs to obtain medical clearance prior to participating in our exercise/fitness programs. Once completed and signed by you, your patient can return this clearance form to me or you can fax it to me at _________________________ (secure fax number of fitness facility). If you have any questions, please feel free to contact me at _______________________________. (phone number and e-mail address of exercise professional responsible for processing screening procedures).

Thank you,

__________________________________________________________________________________________

Name, credentials, and title of exercise professional staff member (e.g., John Smith, BS, ACSM EP-C, Fitness Director)

Please check (√) one of the following:

☐ Not cleared to exercise at this facility – should be referred to a clinically supervised exercise program

☐ Cleared to exercise at this facility

Please check (√) the highest exercise intensity level your patient is cleared for and provide any other restrictions/limitations

☐ Light (<57 to < 64% HR max)

☐ Moderate (64 to < 76% HR max)

☐ Vigorous (76 to < 96% HR max)

☐ Near Maximal to Maximal (> 96% HR max)

Restrictions/Limitations:

Physician’s Name (printed): ____________________________ Physician’s Signature: ____________________________

Phone number: ____________________________ Date: ____________________________