

# Fitness Center

PHYSICIAN'S CLEARANCE for \_\_\_\_\_  
Name (Please Print) Date

**Note To Physician** – The above named individual would like to participate in a fitness program managed by MediFit Corporate Services. Based upon this individual's Health Information Questionnaire, a physician's clearance is required prior to program entry. It is the individual's responsibility to arrange and pay for any necessary charges associated with obtaining this medical clearance, including the cost of a physical exam or other testing. It is your decision whether to administer a graded exercise test (GXT) to your patient to evaluate the patient's capacity for regular exercise.

**Please note that the fitness center is open 24 hours a day and will not be staffed during certain hours when your patient may be exercising.** Please consider the foregoing in deciding whether to provide clearance, and if you provide clearance, advise whether your patient should be allowed to work out when the facility is not staffed or whether your patient should be allowed to use the facilities during staffed hours only.

**Description Of Program** - Prior to beginning the exercise program, each member meets with a qualified fitness professional to discuss the individual's health history, program goals, and to obtain measurements of resting heart rate, blood pressure, height, and weight. This information combined with your recommendations is used to develop an exercise program, which includes warm up, aerobic, strength, and flexibility exercises. *Fitness testing is optional and may include cardiovascular fitness capacity, flexibility, strength, and/or body composition analysis. Fitness testing, if chosen by the member, is not administered in the presence of a doctor and is not diagnostic in nature.*

**PLEASE COMPLETE THE MEDICAL APPROVAL SECTION BELOW AND RETURN IT DIRECTLY TO YOUR PATIENT.** Please attach pertinent GXT results, if available.

**THE INFORMATION SHARED WITH OR PROVIDED TO MEDIFIT PERSONNEL SHALL BE KEPT STRICTLY CONFIDENTIAL BY MEDIFIT. THIS INFORMATION SHALL NOT BE SHARED WITH PSEG PERSONNEL.**

## MEDICAL APPROVAL

The above named patient has medical approval to participate in fitness programs provided by or recommended by MediFit Corporate Services' professional staff at the Fitness Center.

The following restrictions apply (Please specify, including whether the patient should only use the facility during staffed hours. If none, so state):

\_\_\_\_\_  
\_\_\_\_\_

Please list any prescribed medications that may impact exercise response:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

PHYSICIAN STAMP:



### PHYSICIAN INFORMATION (PLEASE PRINT)

Name \_\_\_\_\_ Office Phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_