PHYSICIAN'S CLEARANCE FORM

To be completed by patient:

Patient's Name _____ Phone (_____) _____ _____

Address _____ City _____ State _____ Zip _____

I hereby authorize my physician to complete and forward this form to:

_____

and supply the information requested herein.

_____
Patient's Signature

To be completed by physician:

I have examined this patient on _____

_____
Patient's signature or
Guardian's signature if the
participant is under 18 years of age

Please return or fax to***: (607) 844-6536***
(Please attention to the: ***FSA Fitness Center***)