

Physician's Clearance Form (PCF)

Dear Doctor:

Your patient has applied to register and participate in a personal fitness training program with Dynamic 1on1 Personal Fitness Training. In compliance with the recommendations of The American College of Sports Medicine (ACSM), a stress test is recommended prior to starting an exercise program for any individual with two (2) or more Coronary Risk Factors, unless he is >45 years of age or she is >55 years of age, in which case it would be one (1) or more Coronary Risk Factors. A stress test is also recommended by ACSM for any individual who has major symptoms or signs suggestive of cardiopulmonary or metabolic disease. The patient noted below may be within one of these categories and must have this test or be cleared by you before (s) he may participate in our fitness program. **Please complete all sections in the box below and return this form with your signature and professional stamp**

If you have questions regarding this request, please call Joshua Altshule at (626) 864-0348. Thank you!

Patient's Name: _____

I hereby authorize my physician to complete this form to help insure my health and safety while exercising with Dynamic 1on1 Personal Fitness Training (Joshua Altshule).

Furthermore, I hereby authorize my physician to return the completed form to Joshua Altshule at (626) 864- 0348 / 716 Packsaddle Lane, Walnut CA 91789

Patient Signature _____ **Date** _____

1. Date of last examination: ____/____/____

2. Stress Test:

* Please check accordingly:

____ I feel it is unnecessary for my patient to have a graded maximal stress test. I understand that this patient, as a part of the fitness center registration process, may undergo a sub-maximal exercise test below 85% of subject's maximum heart rate prior to participating in an exercise program. Further, I understand that the sub-maximal test, if conducted, will be administered in the fitness center by an exercise specialist without the presence of a physician.

____ My patient must have a graded maximal stress test, in the presence of a physician, before participating in an exercise program.

(Please note: The fitness center does NOT perform graded maximal stress tests, so, if required, the M.D. is requested to assist the patient in obtaining this test..)

3. My patient may participate fully in a physical activity program consisting of flexibility, cardiovascular and strength training and a sub-maximal cardiovascular fitness assessment administered by exercise specialists without the presence of a physician:

____ Without limitation.

____ With the following limitations. (Please include a brief description of any medical condition that might affect your patient's program.)

4. Verification:

Physician's printed name

Physician's signature Date

• NOTE: THIS PHYSICIAN'S CLEARANCE FORM (PCF) MUST BE RETURNED WITH THE PHYSICIAN'S SIGNATURE AND AN OFFICIAL STAMP OR OTHER EVIDENCE THAT IT CAME FROM A MEDICAL OFFICE (E.G. A TYPED AND SIGNED LETTER ON M.D.'s LETTERHEAD, A FAX WITH M.D.'s OFFICE TAG, ETC.), DOCUMENTING THE CONDITIONS UNDER WHICH THE NAMED PATIENT MAY EXERCISE. THE PCF WILL NOT BE ACCEPTED IF IT IS NOT VERIFIED AS DESCRIBED.

• NOTE: THIS CLEARANCE FORM IS VALID FOR THREE (3) YEARS FROM DATE ACCOMPANYING THE PHYSICIAN'S SIGNATURE UNLESS M.D. SPECIFIES OTHERWISE. M.D. SPECIFICATION: RENEW IN ____ 1 YEAR ____ 2 YEARS ____ OTHER: _____

* The following section needs to be completed by the exercise participant: The form will not be complete without the participant's signature.

I have read, understand and I intend to comply with all exercise limitations that have been placed upon me by my physician. I have been given the opportunity to ask questions about my exercise program and/or limitations. I understand that failure to comply with the limitations that have been set for me could result in serious complications such as injury, illness, or death.

Participant's printed name

Participant's signature

Date

All information collected as a result of this evaluation becomes the sole property of Dynamic 1on1 Personal Fitness Training . None of this information is reviewed or available to any other party without the patient's specific consent.