APPENDIX D

MEDICAL APPROVAL BY HEALTH CARE PROVIDER

Patient Name (print): ________________________________Phone: _____________

Has medical approval to participate in the physical fitness component of the Civilian Fitness Program. I understand that the program includes mild to moderate intensity exercise, and may be conducted in unsupervised groups or individually. I also understand that participation is voluntary, allowing the participant to stop and rest at **any**time he or she desires. Participants will be authorized to exercise at or near the fitness facility on their installation.

If the participant is restricted from performing certain exercises, please list restrictionsand suitable exercises that may be substituted in the space provided below.

The following exercise restrictions and substitutions apply (if none, so state):

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Health Care Provider's Signature:________________________________Date___________

Provider's Print Name/Stamp: ______________________________________

Office telephone number: ______________________

Email Address:_____________________________