Physical Activity Clearance Form

Clearance requested for: _____

Health care provider's name: _____

Please sign the statement that reflects your wishes:

1. ____ This patient may engage in an exercise program **only under clinical supervision**.
2. ____ This patient may engage in an exercise program **only under the supervision of a community-based health club professional**.
3. ____ This patient may engage in **independent (unrestricted)** moderate intensity exercise.

Restrictions: _____

Return form to: _____

Health care provider's signature: _____ Date: _____

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