Physician Authorization Form

Date: ______________________________

Patient Name: ____

Address: ____

____

Phone Number: ___________________________ Date of Birth: _____________________

Date of Last Exam: _________________________

Height: ____________________ Weight: ________________________

Special Considerations: ____

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__________ Yes, my patient can participate.

__________ No, my patient cannot participate at this time due to his/her medical conditions and health status.

Physician's Signature: ____

Print Name: ____

Address: ____

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Phone Number: ______________________ Fax Number: ___________________________

Please return this form to: