Physician's Approval -

Your safety is our primary concern. The Medical History form you filled out identified one or more medical risk factors which may impair your ability to receive bodywork safely. For this reason, you need to have a physician complete and return this Physician's Approval form before you can begin bodywork with a Therapist(s).

I hereby give my physician permission to release any pertinent medical information from any medical records to the staff and/or Therapist/Practitioner(s). All information will be kept confidential. This form will be completed at no cost to staff and/or Therapist(s).

_____ PARTICIPANT Name (Please Print)

_____ Therapist Name (Please Print)

_____ PARTICIPANT Signature

_____ Therapist # (Voice & FAX)

_____ PARTICIPANT Phone #

_____ Today's Date

YES - The above PARTICIPANT has been examined by me and has my approval to participate in a bodywork program. I understand the physical and physiological stressors of the program and see no reason why the above named person should not participate. Any special recommendations and/or contraindications are listed below.

_____ Physician Name (Please Print)

_____ Physician Address (Street)

_____ Physician Signature (M.D.)

_____ Physician Address (City / State / Zip)

_____ Today's Date

_____ Physician Phone Number

Activity	**Intensity Allowed**
Cardiovascular	_____
Resistance Training	_____
Flexibility	_____
Other	_____

Physician's Recommendations/Contraindications: _____

_____

_____

_____

IMPORTANT! If you do not believe the participant should engage in a progressive exercise program, please check the NO box below.

☐ **NO – The above PARTICIPANT has been examined by me and DOES NOT have my approval to participate in a bodywork program.**