St.Vincent | ASCENSION

Physician's Statement and Clearance Form

The health history questionnaire that you have just completed has identified one or more coronary and/or other medical risk factors which may impair your ability to exercise safely. For this reason, you need to have a physician complete and return this medical clearance form before you can begin exercising at St. Vincent Healthy Lives Fitness Center.

I hereby give my physician permission to release any pertinent medical information from any medical records to the staff of St. Vincent Healthy Lives Fitness Center. All information will be kept confidential.

Patient's Signature: _____ Date: _____

Patient's Name: _____ Phone: _____

Information Requested for: St Vincent Healthy Lives Fitness Center

Reason for medical clearance: Exercise program

Physician's Name: _____ Phone: _____

Address: _____ Fax: _____

For Physician Use Only

Please check one of the following statements:

- I concur with my patient's participation with no restrictions.
- I concur with my patient's participation in an exercise program if he/she restricts activities to:

  _____

  _____
- I do not concur with my patient's participation in an exercise program.

  Reason: _____

  Physician's Name (type or print): _____

  Physician's Signature: _____ Date: _____

Please return form to: St. Vincent Healthy Lives Fitness Center

3700 Washington Ave
Evansville, IN 47750
Phone: 81-485-4110 Fax: 812-485-4980