



Physician Release to Exercise

5310 Merchandise Drive
Fort Wayne IN 46825
260-483-1415 ☎
260-969-1867 ☐
www.spiecefmc.com

Patient : _____ Date of Birth: _____ M F
Address : _____ City : _____ Zip : _____
Phone: (H) _____ (W) _____

I authorize the release of appropriate medical information on my behalf to Spiece Fitness

Applicant Signature _____ Date _____

Your patient is interested in participating in the Fort Wayne's Smallest Winner Contest at Spiece Fitness. The program will consist of supervised group training 3 times per week, from March 30, 2010 – July 10, 2010.
Your patient is required to have your clearance to exercise prior to beginning his/her program.
Spiece is requesting that you provide recommendations/restrictions regarding your Patient's participation in any exercise program which is developed for the participant of this event by our fitness professionals.
Please complete the Physician Consultation Form and return it to your patient to submit with the application and other required materials.

I do not know of any medical reason that the applicant may not participate in physical activity.
 The patient may participate with the following recommendations or guidelines: _____

 The patient is **not** cleared to exercise due to a known medical condition.

Medications and effect (if any) on exercise: _____

Physician Signature: _____ Date: ____/____/____
Printed Name: _____ Phone: (____) ____ - ____
Address : _____ City : _____ Zip: _____

If there is any information you would like us to supply, please feel free to note it on the form or contact us at 260-483-1415. Thank you for taking your valuable time to assist us in developing a safe and effective exercise program for your Patient.