



Physician Referral

Date _____

Physician referral requested by certified personal trainer

Client: _____

Phone: _____

Physician: _____

Phone: _____

Your patient has requested to participate in a physical activity program. This request is for the purpose of establishing medical clearance to provide recommendations for beginning an exercise program. Due to the following risk factors, I am requesting medical clearance for your patient. Please complete the following form to indicate any recommendations that would currently affect participation in the testing procedures or physical activity program. The client has signed a statement that it is his/her responsibility to inform the trainer of any changes in their health status.

Primary Risk Factors: _____

Signs or symptoms: _____

I recommend the following:

- Client may participate fully in a physical activity program.
- Client may participate in a physical activity program with the following restrictions:
- Client may not participate in any physical activity program at this time.

Physician's Signature _____

Date _____