



PHYSICIAN'S CLEARANCE for: \_\_\_\_\_  
Name Date

Note to Physician – The above-named individual would like to participate in a company fitness program sponsored by Anschutz Health and Wellness Center. Based upon answers provided on the Health Information Questionnaire, we require a physician's clearance prior to program entry. It is the individual's responsibility to arrange and pay for any necessary charges associated with obtaining this medical clearance, including the cost of a physical exam or other testing. It is your decision whether to administer a graded exercise test to your patient to evaluate the patient's capacity for regular exercise.

Description of Program - Prior to beginning the exercise program, each member meets with a qualified fitness professional to discuss the individual's health history, program goals, and to obtain measurements of resting heart rate, blood pressure, height, and weight. This information combined with your recommendations is used to develop an exercise program, which includes warm up, aerobic, strength, and flexibility exercises. Fitness testing is optional and may include cardiovascular fitness capacity, flexibility, strength, and/or body composition analysis. Fitness testing, if chosen by the member, is not administered in the presence of a doctor and is not diagnostic in nature.

Please complete the MEDICAL APPROVAL SECTION BELOW and either (1) Send to Fax Number: (303)724.9976  
(2) Return it directly to your patient.

### MEDICAL APPROVAL

The above-named patient has medical approval to participate in fitness programs provided by or recommended by Anschutz Health and Wellness Center.

The following restrictions apply (Please specify. If none, so state): \_\_\_\_\_

\_\_\_\_\_

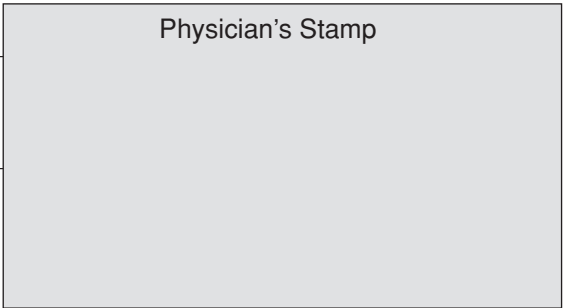
Please list any prescribed medications that may impact exercise response: \_\_\_\_\_

\_\_\_\_\_

Physician's Signature \_\_\_\_\_

Date \_\_\_\_\_

Physician Information (please print)



Name \_\_\_\_\_ Office Phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

# Anschutz Health and Wellness Center

University of Colorado, Anschutz Medical Campus

12348 E. Montview Blvd.

Aurora, CO 80045



# Anschutz Health and Wellness Center

UNIVERSITY OF COLORADO  
ANSCHUTZ MEDICAL CAMPUS

To:	Becca Ruiz	From:	
Fax:		Pages:	
Phone:		Phone:	
Date:		Fax:	

Re: Physician's Clearance for:

- Please Reply       For Review       Please Comment       Urgent       Please Recycle

## NOTES

Please complete the Medical Approval portion of the accompanying Physician's Clearance Form. Please call the number above, if there are any questions. Your patient is eager to participate at Anschutz Health and Wellness Center. We appreciate your responding to our request for clearance to exercise. Please either (1) send to fax number listed above or (2) return it directly to your patient.

Thank you,

Anschutz Health and Wellness Center Team

## PATIENT AUTHORIZATION

I hereby authorize Anschutz Health and Wellness Center to fax this document to my physician and for my physician to release my medical information to Anschutz Health and Wellness Center. I understand that confidentiality cannot be guaranteed when communicating via facsimile.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If you are under the age of 18, a parent or guardian must sign this release form.

Parent / Guardian Signature: \_\_\_\_\_

## NOTICE

The information contained in this facsimile is private and confidential and intended only for the use of the recipient named above. The authorized recipient is prohibited from disclosing this information to any other party unless required to do so by law or regulation and is required to destroy the information after its stated need has been fulfilled.

If you, the reader, are not the intended recipient, you are hereby notified that any dissemination, distribution, duplication, or action taken in reliance on the contents of any part of this communication is strictly prohibited. If you have received this communication in error, please destroy this information and notify the sender at the telephone number or fax number listed below. Unauthorized access to confidential information is subject to federal and state laws and could result in personal liability, fines, and imprisonment.