Medical Clearance Form

StrengthForLifeNY.org

Dear Doctor,

Your patient, _____ , wishes to take participate in Strength For Life wellness services. Activities include strength training, yoga, tai chi, line dancing, walking group and weekend wellness retreat. All Strength For Life programs are specifically designed for cancer patients and survivors and are facilitated by Certified Fitness Instructors.

By completing this form, you are not assuming any responsibility for the administration of Strength For Life programs.

Please identify any recommendations or restrictions for your patient's wellness program below.

☐ The patient may participate without restrictions.

☐ The patient should not participate in the following activities:

_____

_____

Physician's Name:_____

Physician's Signature:_____

Address:_____

Email Address:_____

Contact Number:_____