Medical Clearance Form

StrengthForLifeNY.org

***Please return completed form to StrengthForLifeNY@gmail.com**

Dear Healthcare Professional,

Your patient, _____, wishes to participate in Strength For Life's wellness services. Activities may include strength training, yoga, tai chi, line dancing, walking groups and weekend wellness retreats. All Strength For Life programs are specifically designed for cancer patients and survivors and are facilitated by qualified practitioners.

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 Signature:_____

Physician's Printed Name:_____

Address:_____

Email Address:_____

Tele. Number:_____