CRMC Fitness Center

Unsupervised Exercise Participation – Physician Approval Form

Section I: Medical Information Release

(To be completed by participant)

NAME: _____(please print)
HOME ADDRESS: _____
PHONE: _____CITY/ STATE/ ZIP: _____

Cullman Regional Medical Center ("CRMC") requires all participants in unsupervised exercise at its CRMC Fitness Center to submit a completed Physician Approval form prior to participation. Participation is contingent upon your physician's approval.

I hereby give my physician permission to release any pertinent medical information from my medical records to the staff of the CRMC Fitness Center. I understand that this information will be kept confidential.

PARTICIPANT SIGNATURE: _____DATE: _____

Section II: Physician Approval

(To be completed by participant's physician)

Dear Physician:

Your patient, named above, has expressed an interest in exercising without supervision or assistance at CRMC's Fitness Center. No CRMC personnel will be available to assist or supervise your patient's exercise at CRMC's Fitness Center.

Please select the appropriate statement below concerning this patient and update CRMC and the patient if your opinion changes as a result of the patient's health condition:

[ ] no restrictions apply and the above named patient may medically exercise at CRMC fitness without supervision or assistance.
[ ] the following restrictions should apply: _____
_____
[ ] participation is not recommended at this time (If checked, patient will be denied participation.)

PHYSICIAN SIGNATURE: _____
DATE: _____ PHONE: _____
PHYSICIAN NAME: (print or type): _____
ADDRESS: _____