Provider Approval Form

Patient Information: ____
Last Name First Name DOB

Please check the statement that accurately reflects your wishes.

☐ **I APPROVE** this person to participate in an independent exercise program
Recommendations/Restrictions: ______________________________
____

☐ **I DO NOT APPROVE** this person to participate in an independent exercise program. If this is checked, the individual will not be accepted for membership.

☐ **MEDICAL HOLD** Begin date ___________ End date ___________
Reason: ____

___________________________________ ________________
PROVIDER SIGNATURE **DATE**

Fax completed form to 503.418.9040

Provider Information: ____
Name (please print)

Clinic Name: _________________ Phone: ______________ Fax: ____________

Confidentiality Notice: This transmittal is intended only for the use of the individual or entity to which it is addressed and may contain information that is privileged and confidential. If the reader of this message is not the intended recipient, you are hereby notified that any disclosure, distribution or copying of this information is strictly prohibited. If you received this transmission in error, please notify us immediately. Thank you.