Medical Clearance Form

Dear Physician:

_____ has applied to enroll in the Active Steps exercise program. Active Steps provides guided exercise programs for diabetic/dialysis patients. The program is held two times per week for ten weeks. Please reach out to the patient via telephone at _____ to arrange class times.

A specific individualized exercise program is designed for each participant depending on their needs and abilities. Exercise programs will include stretching, flexibility and core strength exercises. Modified resistance training is progressively added to increase upper and lower body strength and bone density. The client's program is carefully monitored so that their abilities and needs are consistently re-evaluated.

If you know of any medical or other reasons why participation in Active Steps by the applicant would be unwise, please indicate on this form.

If you have any questions about the program, do not hesitate to contact Renée Aten?????

Report of Physician

_____ I APPROVE the applicant to participate in Active Steps with NO restrictions

_____ I APPROVE the applicant to participate in Active Steps on a RESTRICTED basis. The applicant should not engage in the following activities:_____
_____
_____

_____ I DO NOT approve the applicant to participate in Active Steps. Please include reasons, if appropriate:_____
_____
_____
_____

Physician's Signature_____ Date_____

Address_____ Phone_____

Form may be faxed to 231-352-9663 or mailed to 102 Airport Road Frankfort, MI 49635