Date: _____

MEDICAL CLEARANCE FORM

Dear Doctor: _____

_____

Your patient _____ has applied for enrollment in GETFIT, CPT, LLC a personal training service with Certified Personal Trainers and to participate in a structured exercise program. Exercise programming is performed by Exercise is Medicine (EIM) credentialed trainers. The training services offered include virtual exercise programming and video check-ins for technique assessment. Your patient will be exercising either at a facility of their choosing or at home. As a participant in this program, she/he may be participating in the activities named below. Under the American College of Sports Medicine guidelines, medical clearance has been requested for the following reasons:
They had the following risk factors listed on the PARQ: _____
_____.

Fitness Testing: The purpose of fitness testing is to assess cardiorespiratory fitness, muscular strength and endurance, body composition, and flexibility. The cardiorespiratory test is a submaximal test utilizing a cycle ergometer, bench stepping, a treadmill walk/run test, or similar test. Muscular strength and endurance tests require body calisthenics and/or use of exercise equipment such as a bench press. Body composition analysis is performed via skinfold calipers, bioelectric impedance, and/or tape measurement. Flexibility testing utilizes active movements as the straight leg raising test and sit and reach test.

Structured Exercise Program: The purpose of an exercise program is to develop and maintain cardiorespiratory fitness, muscular strength and endurance, body composition, and flexibility. A structured exercise program is given to each participant based on needs and interests and physician recommendations. All exercise programs include warm-up, exercise at target heart rate, and cool-down (except for muscular strength and endurance training, in which target heart rate is not a factor). The programs may involve walking/jogging/running, swimming, cycling, rhythmic aerobic exercise (low-moderate-high impact classes), calisthenics, and/or strength training. All programs are designed to place a gradually increasing workload on the body in order to improve overall fitness and muscular strength. The rate of progression is regulated by target heart rate and/or perceived rate of exertion. The personal training services by GETFIT, CPT, LLC are 100% virtual. The patient will be participating from their home, or a facility of their choice. It is their responsibility to ensure they are exercising in a safe location.

To facilitate the review and approval of your patient's application for testing and/or exercise program we require recent (within 12 months) medical information and your recommendations as requested on the reverse side of this form. If you have any questions about this process, please feel free to call our program staff at **812-853-7840.**

Enclosure: Medical Information and Recommendations Form

Medical Information and Recommendations Form

Patient Name: _____ Date of Birth: ____/ 00 /____
MM / 00 / YY

PATIENT DATA

Age _____yrs. Height _____in. Resting Heart Rate ____

BMI _____ Weight _____lb Blood Pressure: ____/____

Medications: _____

If your patient is taking medications that will affect their ability to take part in the above activities, please indicate the manner of the effect (eg, raises/lowers heart rate/blood pressure etc).

Are there any specific exercise recommendations/restrictions? Y/N?
If yes, please specify:

BLOOD ANALYSIS

Please include recent lab values listed below if available. Please include any other relevant objective data with comments/recommendations_____

_____ Date:

Total Cholesterol	_____mg/dl	CHOL/HDL RATIO	_____
HDL Level	_____mg/dl	Triglycerides	_____mg/dl
LDL Level	_____mg/dl	Glucose	_____mg/dl

FOR PHYSICIAN USE

RESTING EKG: ☐ not done ☐ was within normal limits ☐ was abnormal Test Date: _____

EKG STRESS TEST: ☐ not done ☐ was within normal limits ☐ was abnormal Test Date: _____

Abnormal Findings: _____

_____

Based upon my observation / examination, it is my opinion that this patient (indicate below):

_____ May participate in a fitness testing/exercise program **without any restrictions.**

_____ May participate in a fitness testing/exercise program **with the following restrictions:**

_____

_____ **Should NOT** engage in a testing/exercise program at this time for the following reasons:

_____

_____

Is there anything specific our trainers at GETFIT, CPT, LLC. Need to be aware of to ensure safe exercise programming for your patient?_____

Physician's Signature: _____ Date: _____

Printed Name & Address or stamp: _____ Phone: _____

_____

_____

MEDICAL RECORDS RELEASE AUTHORIZATION

I give permission to release any medical information that may be beneficial for preparing an exercise program to GETFIT,CPT,LLC.

Patient Signature _____ Date _____

Patient Name _____

I have reviewed, understand, and will abide by all recommendations made by my doctor as stated above.

Participant Signature: _____ Date: _____