Nutrition Works LLC

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Exercise Clearance Request

This form should be completed by your physician and faxed to Nutrition Works, LLC at 207-347-4281.

Patient's Name: Date of Birth:

Physician's Name: Fax Number:

Number of Pages:

Physician's Office Use Only:

To the physician: Please sign and return this form indicating whether your patient, named below, is cleared for exercise or has limitations or restrictions:

Your patient is receiving Medical Nutrition Therapy at Nutrition Works, LLC, provided by a registered, licensed dietitian. As part of your patient's treatment plan we would like to make recommendations, with your input, regarding the type, duration and intensity of physical activity. Please check the appropriate box and fax back to our office at **207-347-4281**.

_____ The participant may fully take part in a physical fitness program including aerobic, muscular strength and flexibility training without restriction.

_____ The participant may take part in a physical fitness program with the following recommended restrictions (please briefly note any specific concerns or precautions you advise):
_____
_____
_____
_____

Physician's Signature: _____ Date: _____