

Provider \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your patient, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has enrolled in the InSHAPE program, which provides access to exercise classes, activities, and a personal trainer. Medical clearance is required for participation from their PCP.

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 Participant has no limitations

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 Participant has the following limitations:

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 Participant is NOT medically cleared to participate in the InSHAPE program.

 Additional comments:

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 Provider signature Date

Please fax back to (810) 648-4338, Attn: Abbey Bowerman 810-583-0447 – InSHAPE program