VERIFICATION OF MEDICAL LIMITATIONS/RESTRICTIONS

Must be returned via USPS Certified Mail *within 30 days of completion*

To be completed by the member:

Member Name: (please print) _____

Club Name: _____ Phone Number: _____

Form must be completed by Licensed MD, DO or PA-C (where allowed by state law). (Excludes Nurse Practitioners, Chiropractor, etc.)

I hereby authorize the undersigned Physician to provide the information in this Verification of Medical Limitations/Restrictions to my gym's billing company and agree to the terms hereof.

_____ _____/_____/_____

Member Signature Date

To be completed by the Physician:

Please fill out this form regarding your patient (listed above). Be aware that the purpose of this document is to allow your patient to alter the terms of a legally binding contract with a gym.

Date Condition Began: _____/_____/_____

This condition: (MUST check one)

- ☐ Does not allow my patient to utilize a gym membership under any circumstances, or in any way.
- ☐ Would not affect gym membership use.
- ☐ Allows my patient limited use of a gym membership as explained below:

  _____

The duration of this condition: (MUST check one)

- ☐ Ends on _____/_____/_____ (date)
- ☐ Still persists and will last for (_____weeks/_____months/_____years) from the onset of the condition.
- ☐ Still persists and will be permanent.

I certify that the patient listed above is my patient and is under my care. I also certify that a thorough physical examination and any necessary testing was done to make these conclusions regarding my patient's condition. I understand that by making these representations, I will make myself available for necessary testimony in a court of competent jurisdiction to verify that the above-referenced patient's condition is stated truthfully and that any costs associated with such testimony will be incurred by the patient.

_____ _____/_____/_____

Physician's Signature Date

_____ _____

Physician Printed Name Medical License Number