

EVERFIT HEALTH, WELLNESS & PHYSICAL THERAPY CENTER
2200 Wallace Blvd. Suite E
Cinnaminson, NJ 08077
Phone: 856-829-0015 Fax: 856-829-0043

Dear Dr. _____,

Your patient _____, DOB _____ would like to start an exercise program. EverFit requires our clients to obtain physician approval prior to starting his/her exercise program.

In the spaces provided, please indicate any medical condition(s) that may interfere with your patient's ability to participate in an exercise program consisting of strength, flexibility and cardiovascular training. Please include any specific recommendations or restrictions that are appropriate for your patient in the exercise regimen.

If your patient is taking any medications that will affect his/her heart rate response to exercise or if through stress testing you have determined an appropriate target heart rate, please provide us with this information. Thank you.

Sincerely,

EverFit, LLC

I _____ (Member) give authorization to my Physician to provide EverFit with appropriate medical information related to my capacity to exercise.

Signed: _____ Date: _____

.....
Physician
Comments _____

The above patient has my approval to participate in an exercise program and fitness assessments with recommendations/restrictions stated above.

Signed: _____ Date: _____

If you have any questions, please feel free to call us!

PLEASE FAX BACK TO US ASAP.....THANK YOU!