DATE: _____

The Community Hospital Fitness Pointe®
9950 Calumet Avenue, Munster, IN 46321
Phone: (219) 924-5FIT
Fax: (219) 924-8581

Dear Dr. _____ Phone number: _____City/State: _____

Your patient, _____ D.O.B. _____

is interested in becoming a member of The Community Hospital's Fitness Pointe, Northwest Indiana's Premier Medical Fitness Facility. Their signature,_____, hereby authorizes the release of medical information pertinent to participating in a fitness program.

Patient's Request:

- ☐ **Cardiovascular (i.e. Treadmill, Track, Bike, etc.)**
- ☐ **Resistance Training/Strength (i.e. Light Hand Weights, Resist-a-Bands, Strength Equipment, etc.)**
- ☐ **Water Exercise**
- ☐ **Group Exercise Class**

Your patient requests participation in the above <u>checked</u> activities.

Please indicate your approval by signing below.
Should you not approve, then indicate in the lines provided below.

PHYSICIAN'S SIGNATURE: _____ DATE: _____

****Please provide additional information necessary:**

_____

_____

_____

Sincerely,
Ann Leader, B.S.
Fitness Assessment and Program Support Supervisor
The Community Hospital Fitness Pointe

FAX TO: (219) 924-8581