

DATE: _____



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 checked activities.

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

<p>PHYSICIAN'S SIGNATURE: _____ DATE: _____</p>

****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**