DATE: _______________

Dear Dr. ________________ Phone number: ________________City/State: ________________

Your patient, ________________________________ D.O.B. ________________

is interested in becoming a member of 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.

PHYSICIAN'S
SIGNATURE: ____________________________________ DATE: __________________

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

____

____

____

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

FAX TO:
(219) 924-8581