PHYSICIAN RELEASE FORM

Patient's Name: _____

Physician Name: _____

Physician's Address: _____

_____

City: _____ State: _____ Zip: _____

Diagnosis: _____

_____

_____

_____

I hereby give medical approved to the person named above to participate in a post-rehabilitation program that may include cardiovascular, resistance training, and functional conditioning for the body.

Please note any exercise recommendation or restrictions.

Please note any medication that may affect patient's response to exercise.

Physician's Signature: _____ Date: _____

When complete, please fax to appropriate team member of Maple Tree Cancer Alliance (_____).