Maple Tree
CANCER ALLIANCE

PHYSICIAN RELEASE FORM

Patient Name: _____ **Patient Email:** _____

Patient Phone Number: _____ **Patient DOB:** _____

Physician Name: _____

Physician Phone Number: _____

Physician Address: _____
STREET

_____
CITY STATE ZIP

Exercise Restrictions: _____

_____

_____

Medications that may affect exercise response_____

_____

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

_____
PHYSICIAN'S SIGNATURE

_____
DATE

Please take this form to your physician before starting.

When complete, please fax to 1-937-688-3940 Attention: Maple Tree Cancer Alliance