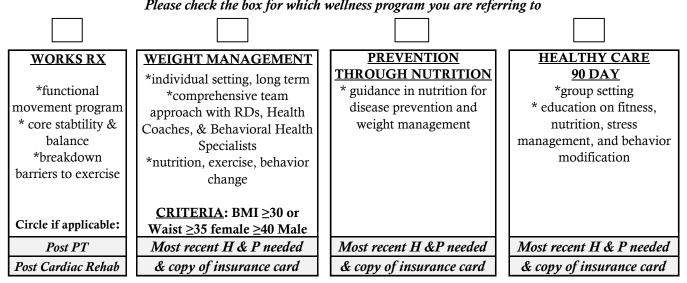


Please complete and fax to The Works Attn: Carrie Richer (603) 609-6306

Patient's Name:	Physician Office:
Address:	Referring Physician:
<u>D.O.B</u>	
Phone Number:	Reason for Referral/Diagnosis:
Please complete this medical clearance so that the patient named above may engage in the specified wellness program below at The Works Health and Fitness Center.	
Places shack the box for which wellwass another was referring to	



Please check the appropriate situation for the patient named above.	
YES the patient named above is cleared to participate in all forms of exercise	
Limitations/Contraindications:	
PHYSICIAN SIGNATURE:	DATE: