

**Welborn Foundation Wellness & Fitness Center  
Physician's Statement and Clearance Form**

At the Welborn Foundation Wellness & Fitness Center (WFWF Center), your safety is our primary concern. The health history questionnaire that you have just completed has identified one or more coronary and/or other medical risk factors that may impair your ability to exercise safely. For this reason, you need to have a physician complete this medical clearance form before you can begin exercising at the WFWF Center.

**I hereby give my physician permission to release any pertinent medical information from any medical records to the staff at the WFWF Center. All information will be kept confidential.**

**Patient's Name** \_\_\_\_\_ **Birth Date** \_\_\_\_\_

**Patient's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Information requested for \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Reason for medical clearance \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Address \_\_\_\_\_

**For Physician Use Only**

Please check one of the following statements:

I concur with my patient's participation with no restrictions.

I concur with patient's participation in an exercise program if he/she restricts activities to :  
\_\_\_\_\_  
\_\_\_\_\_

I do not concur with my patient's participation in an exercise program (if checked, the individual will not be allowed to use the WFWF Center)

Reason \_\_\_\_\_

Physician's name (type or print) \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

Please return to: **Welborn Foundation Wellness & Fitness Center  
Ivy Tech Community College  
3501 First Ave.  
Evansville, IN 47710  
Phone (812) 429-0585  
Fax (812) 429-1398**