OREGON HEALTH & SCIENCE UNIVERSITY

march
wellness & fitness center

Phone: 503.418.6272 Fax: 503.418.9040

Provider Approval Form

This is an exercise approval form for your patient listed below.

Provider Information: _____
Name (please print)

Clinic Name: _____ **Phone:** _____ **Fax:** _____

Please check the statement that accurately reflects your wishes.

☐ I **APPROVE** of this person participating in an independent exercise program

Recommendations/Restrictions: _____

_____

☐ I **DO NOT APPROVE** of this person participating in an independent exercise program. **If this is checked, the individual will not be accepted for membership.**

☐ Place membership on **MEDICAL HOLD**. **Begin date** _____ **End date** _____

Reason: _____

_____

PROVIDER SIGNATURE **DATE**

Patient Information: _____
Last Name **First Name** **DOB**

_____
Street Address **City** **State** **Zip** **Phone**

Please fax completed form to 503.418.9040