



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

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