MICHIGAN MEDICINE
UNIVERSITY OF MICHIGAN

Dear Dr. _____,

Your patient, _____is interested in participating in an exercise program offered in the Department of Physical Medicine & Rehabilitation, Transitions Training Studio.

In order to participate in this program, identification of any contraindications/restrictions is appreciated below:

Physician's Recommendations

	Client is approved to participate in your exercise program with no contraindications/restrictions.
	Client is **not** appropriate to participate in your exercise program.
	Client is approved to participate in your exercise program with the following contraindications/restrictions:

Physician's signature		Date
Physician's name (print)	Phone	Fax
Address	City	State & Zip

You may fax the exercise clearance to us at 734-763-3715, attn: Transitions Training Studio Staff or simply sign and return to your patient.

If you have any questions, feel free to contact our Transitions Training Studio Staff at 734-232-1196.

Sincerely,

Transitions Training Studio Staff