



Physician Approval Form

Section I: Medical Information Release

(To be completed by client)

Name: _____ Phone: _____

Home Address: _____

City/State/Zip: _____ DOB: _____

InMotion™ policy regarding participation in programming states that all clients are required to submit a completed Physician Approval Form prior to participation. Participation is contingent upon your physician's approval.

I hereby give my physician, named below, permission to approve/disapprove my participation in InMotion's programming.

Physician: _____ Phone: _____

Participant Signature: _____ Date: _____

Section II: Physician Approval

(To be completed by client's physician)

The client, named above, has expressed an interest in participating in InMotion™ programming. Their participation is contingent on: (a) their Parkinson's Disease diagnosis, and (b) their ability to safely participate in physical exercise. Please select the appropriate statements below concerning this client:

Parkinson's Disease Diagnosis

- () The client *has been* diagnosed with Parkinson's Disease
() The client *has not been* diagnosed with Parkinson's Disease

Ability to Participate in Physical Exercise

- () No restrictions apply
() Participation is NOT recommended at this time
() Other: _____

Physician Signature: _____ Date: _____

Questions can be directed to:

Erin Shelton, Program & Client Relations Manager
(216) 342-5786 or eshelton@beinmotion.org

PLEASE RETURN TO: InMotion™

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