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 (or related) diagnosis, and (b) their ability to safely participate in physical exercise.

Please select the appropriate statements below concerning this client:

Diagnosis

- ☐ The client *has been* diagnosed with an accepted diagnosis
- ☐ The client *has not been* diagnosed with an accepted diagnosis

Ability to Participate in Physical Exercise

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

Accepted Diagnoses

- ☐ Corticobasal Degeneration
- ☐ Dementia with Lewy Bodies
- ☐ Multiple System Atrophy
- ☐ Parkinson's Disease
- ☐ Progressive Supranuclear Palsy
- ☐ Vascular Parkinsonism

Physician Signature: _____ Date: _____

Questions can be directed to:
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PLEASE RETURN TO: InMotion™
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