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: _____