



# Physician Approval Form

(revised January 2026)

## 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 one of the following accepted diagnoses:

*Parkinson’s Disease, Corticobasal Degeneration, Dementia with Lewy Bodies, Multiple System Atrophy, Progressive Supranuclear Palsy, Vascular Parkinsonism*

( ) The client **has not been** diagnosed with an accepted diagnosis (listed above)

### **Ability to Participate in Physical Exercise**

( ) No restrictions apply

( ) Participation is NOT recommended at this time

( ) Other: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**QUESTIONS? PLEASE CONTACT:**

(216) 342-4417 or [administration@beinmotion.org](mailto:administration@beinmotion.org)

**PLEASE RETURN TO:** InMotion®

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