

Dear Physician:

_____ has inquired about becoming involved in our Adult Fitness Program. This program involves participating in activities designed to improve cardiovascular fitness, strength and flexibility. Each participant is provided with an individually prescribed exercise program. The prescribed program is based upon the results of the following testing:

- Baseline fitness testing utilizing the Rockport 1 mile walk test, core strength assessments.
- Body Composition and Ideal Weight Determination utilizing skinfold measurements and bioelectric impedance scale
- Flexibility Testing and Stretching Routine

Before entering our program, each participant is required to obtain clearance from his/her personal physician. Because the American College of Sports Medicine recommends that individuals 35 years and older have a complete physical before an exercise program, we would ask that this procedure be followed.

Should you have any questions, please notify me. Thank you for your cooperation.

Sincerely,

Dr. Kris Cleveland, PT, DPT
Assistant Professor/Director SMSU Wellness and Human Performance Center
Physical Therapist

I have examined _____ and found him/her to be physically capable to participate in the described exercise program.

Physician's Signature

Physicians Printed Name & Clinic

Date _____

Phone _____

**Please FAX completed form to: (507) 537-6323
ATTN: Dr. Kris Cleveland, PT, DPT
Southwest Minnesota State University**

**Forms may also be returned by mail to the address below.

Telephone (507) 537-6178 • Toll-Free (800) 642-0684 • Fax (507) 537-6323
1501 State Street, Marshall MN 56258-1598 • www.SMSU.edu

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