SID JACOBSON JCC
NANCY MARX CANCER WELLNESS CENTER

PHYSICIAN'S CLEARANCE

DATE:_____

PATIENT/CLIENT'S NAME_____ DATE OF BIRTH_____

DATE OF LAST PHYSICAL EXAMINATION_____

DIAGNOSIS_____

UNDERGOING TREATMENT_____

COMPLETED TREATMENT_____

LIMITATION/RECOMMENDATIONS REGARDING PARTICIPATION IN A PHYSICAL ACTIVITY PROGRAM:

_____

_____

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_____

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_____

PHYSICIAN'S SIGNATURE_____ DATE_____

PHYSICIAN'S NAME (PLEASE PRINT)_____

ADDRESS_____

_____

PHONE_____ EMAIL_____

OFFICE MANAGER CONTACT INFORMATION_____

Please hand to your patient or FAX to Randy Hight, LCSW,OSW-C at 516.484.7354