



## PHYSICIAN RELEASE

Patient Name: \_\_\_\_\_  
(please print)

Patient Phone #: \_\_\_\_\_

I, \_\_\_\_\_, wish to begin an exercise program at **RESHAPE, LLC**.  
(patient signature)

Please list below any physical limitations or restrictions and any medications that might assist my instructors in designing an exercise program specific to my needs.

\_\_\_\_\_  
CURRENT MEDICATIONS:

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\_\_\_\_\_ I RECOMMEND THAT THE PATIENT PARTICIPATE IN AN EXERCISE PROGRAM BUT URGE CAUTION DUE TO THE FOLLOWING LIMITATIONS and/or /RESTRICTIONS:

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\_\_\_\_\_ I **DO NOT** RECOMMEND THAT THE PATIENT PARTICIPATE IN AN EXERCISE PROGRAM.

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Except as stated above, I am not aware of any consideration, which under ordinary circumstances would interfere with this patient performing moderate level physical activity. He/she may exercise at his/her own risk.

\_\_\_\_\_ M.D.  
Physician Name (please print)

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Office Phone Number

Thank you for your cooperation and your commitment to your patient's overall wellness.

Sincerely,  
**RESHAPE, LLC**



nicole@reshapellc.com



740.972.1709



Delaware, Ohio