Present this letter to your physician with the following medical clearance form and have them fax or email it back to us.

Dear Dr. ___________________________,

Your patient, ____________________________, has applied for membership to the Faculty & Staff Fitness Program, Department of Human Sciences/Kinesiology at The Ohio State University.

This program involves a symptom limited graded cardiorespiratory fitness test for the evaluation of each participant's initial fitness level. This test, performed on a treadmill, is administered by staff and students in exercise physiology. Also, included is a measurement of upper and lower body strength, and body composition. The participant's exercise recommendations, based on these results, may include but are not limited to any combination of the following: walking, jogging, swimming, or strength training of specific muscle groups. The program sessions are always supervised.

By completing the enclosed medical clearance form, we acknowledge that you are not assuming any responsibility for our administration of this program. However, if you know of any medical or other reasons why participation in this fitness program would not be in the best interest of this individual, we would appreciate your indication on the enclosed Report of the Personal Physician form. Thank you for your help.

Sincerely,

Maggie Roe
Faculty and Staff Fitness Program Manager
Department of Human Sciences - Kinesiology
The Ohio State University
A042 PAES Building
305 Annie and John Glenn Avenue
Columbus, OH 43210-1224

Phone: 614-247-0287
Fax: 614-688-3432
Email: EHE-FSFP@osu.edu

Enclosure

The Ohio State University
Faculty & Staff Fitness Program
Physician's Medical Clearance Form

REPORT OF PERSONAL PHYSICIAN

Patient Name: ____

Please check the most appropriate box:

☐ 1. I know of no reason why they may not participate.

☐ 2. I believe they could participate, but urge caution because of:

____

____

☐ 3. I recommend they not participate due to:

____

____

Physician's Signature: ____

Physician's Name (Print): ____

Physician's Address: ____

____

Physician's Fax number: ____

The below signature is required of all individuals wishing to join FSFP.
I hereby authorize the release of my fitness evaluation results to the physician named above.

Patient Signature: ___________________________________ Date: ___________

(Revised 12/24)