MEDICAL FITNESS CENTER

LOGAN HEALTH

MEDICAL FREEZE/RELEASE

This is an exercise approval form for your patient listed below:
Patient Information:

_____

Last Name First Name Member Number

_____

Street Address City State Zip Phone

I give The Logan Health Medical Fitness Center permission to contact my physician for approval of my participation in an independent exercise program at LHMFC.

_____

Patient Signature Date

Information Below Completed by Provider:

Please check the statement that accurately reflects your wishes.

- □ I **APPROVE** of this person participating in an independent exercise program.
  Recommendations/Restrictions_____
- □ I **DO NOT APPROVE** of this person participating in an independent exercise program.
  If this is checked, the individual will not be accepted for membership.
- □ Place membership on **MEDICAL HOLD**. Begin date: _____
- □ **Release** membership from medical hold. End date: _____
  Recommendations/Restrictions: _____
- □ **COVID Medical Concerns** Begin date: _____
  End date: _____

_____

PROVIDER SIGNATURE DATE

Provider Name (print): _____

Clinic Name: _____ **Phone**: _____ **Fax**: _____

Please fax completed form to 406-751-6983 or call 751-4107 with questions.

ACCOUNT CHANGE REQUEST: Received by: Date: