MEDICAL FITNESS CENTER

LOGAN HEALTH

MEDICAL FREEZE/RELEASE

This is an exercise approval form for your patient listed below. Membership will automatically cancel after 12 months of medical hold.

Information Below Completed by Fitness Center Member:

_____

Last Name First Name Access Card #

_____

Street Address City State Zip Phone

Freeze: Member Only_____ Entire Account_____

_____

Member 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.**

MEDICAL HOLD BEGIN DATE: _____/_____/_____ **MEDICAL HOLD RELEASE DATE**: _____/_____/_____

□ **Release** membership from medical hold.
Release Restrictions (if any): _____

_____

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: