Inspirit Self Training

Encouragement. Knowledge. Power.

Date _____

Dear Doctor:

Your patient _____ wishes to start a personalized training program. Your patient may have made a positive response to the PAR-Q health screening questionnaire and now requires medical clearance to begin the program.

The activity will involve 45 minutes of continuous vigorous strength training exercise using light weights and short rest periods in workouts 3 times each week. The program will also include light static stretching.

Further, the client may wish to add continuous exercise such as walking, cycling, stepping or elliptical machine training.

1. **If your patient is taking medication that will affect their heart rate response to exercise, please indicate the manner of the effect (raises, lowers, or has no effect on the heart rate response).**

   Medication: _____

   Effect: _____

2. **Please indicate any recommendations or restrictions that are appropriate for your patient in this exercise program.**

   _____

   _____

   _____

3. **Please indicate your approval to begin the exercise program if appropriate:**

   _____ has my approval to begin an exercise program with the recommendations or restrictions stated above.

   Signed_____ Date: _____ Phone: _____

Thank you for your assistance.

Please call (847) 608-8772 if you have any questions.

ACE CERTIFIED