



REGIONAL THERAPY CENTER
A SERVICE OF SARATOGA HOSPITAL

Health & Fitness Gym
6 Care Lane
Saratoga Springs, NY 12866
518-583-8383

After Therapy Club Physician Clearance

Participant's Name: _____ Date of Birth: - ____ - ____

Address: _____

Phone #: _____

The above named individual may participate in the Regional Therapy Center (RTC) After Therapy Club, a service of Saratoga Hospital.

I understand that the above named individual is planning on exercising (e.g., stretching, strengthening, conditioning and aerobic exercises) at the RTC Health and Fitness Gym as part of his/her health and fitness goal.

No special monitoring is necessary and supervision by program staff is not required for this individual.

Physician: _____ Date: _____