REGIONAL THERAPY CENTER
A SERVICE OF SARATOGA HOSPITAL

Pre-Habilitation Program Physician Clearance

Participant's Name:_____ Date of Birth: _____

Address:_____

Telephone Number: _____

Medical Condition(s) which could impact, or be a concern for, an exercise/conditioning program for this participant (please list):

Cardio-Pulmonary: _____

Joint Problems: _____

Other: _____

_____

Exercise/Conditioning Restrictions (If any):

Lifting/resistance: _____

Other: _____

The above named individual is able to participate in the Pre-Habilitation Program of the Regional Therapy Center.

No special monitoring is necessary and supervision is not required as this individual is able to participate in the Pre-Habilitation Program independently following instruction in the exercises appropriate for this participant's condition and upcoming procedure or treatment.

Physician:_____ Date:_____