

PHYSICIAN AUTHORIZATION FORM

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| --- | --- |
| (Highlight indicates areas to be completed by VCE personnel: remove this statement before printing/sending) | |
| **Physician /**  **practice** |  |
| **Address** |  |
| **Phone number** |  |
| **Fax number** |  |
| **Patient Name** |  |
| **Program** |  |
|  | Yes, my patient can participate. |
|  | Yes, my patient can participate with the following limitations: |
|  | No, my patient cannot participate at this time due to his/her medical conditions and health status. |
| **Physician**  **signature:** |  |
| **Printed name:** |  |

This form may be faxed to , given to patient, or mailed to: INSERT ADDRESS HERE

Please return this form by: (Date)

Return Contact Information Here

Date

Dear Dr. ,

Your patient, , would like to participate in a Virginia Cooperative Extension (VCE) program that involves physical activity.

Part of the mission of VCE is to “put scientific knowledge to work through learning experiences that improve economic, environmental, and social well-being.” Through a partnership of the land-grant universities of Virginia and community-based faculty and staff, these programs are developed and delivered through best practices and evidence and aim to improve health behaviors.

To determine if a participant may have a contraindication to physical activity, we have participants complete the Physical Activity Readiness Questionnaire before engaging in this particular program. Your patient has indicated an answer that requires us to obtain physician approval before he/she engages in the program, which includes moderate intensity physical activity (tailor as needed).

Please complete and sign the enclosed authorization form. If you have any further

questions about this program, please call me at .

Sincerely,

Name Position Location