District of Columbia Office on Aging
Senior Wellness Centers

Physician Clearance to Participate in the Physical Fitness Program

To: Primary Physician

Your patient _____ contacted the circled D.C. Office on Aging Wellness Center, as indicated below, regarding participation in the physical fitness program. This program involves access to both cardio and strength/endurance fitness equipment. All participants are encouraged to exercise their way up to 85% of their age predicted maximum heart rate.

Your permission is required in order for your patient to participate in the physical fitness program. The attached Physician Clearance Form (see reverse) is intended to provide information about your patient's ability to engage in exercise or strenuous physical activity. **Please note that Fitness Specialists are not medically trained**.

Please contact the Wellness Center circled below for questions.

Please Circle the Wellness Center Location:

Ward 1: Bernice Fonteneau Wellness Center
3531 Georgia Ave NW
Tel: (202)-727-0338

Ward 4: Hattie Holmes Wellness Center Center
324 Kennedy St. NW
Tel: (202)-291-6170

Ward 5: Model Cities Wellness Center Center
1901 Evarts St. NE
Tel: (202)-635-1900

Ward 6: Hayes Senior Wellness Center
500 K St. NE
Tel: (202)-727-0357

Ward 7: Washington Seniors Wellness
3001 Alabama Ave SE
Tel: (202)-581-9355

Ward 8: Congress Heights Wellness
3500 MLK Jr. Ave SE
Tel: (202)-563-7225

Please note that **this Clearance Form is valid for one year only,** effective from the date of the physician's signature above. Following the one year expiration, a new form must be submitted and signed by a physician on an annual basis for the duration of the patient's participation in the physical fitness program.

PHYSICIAN CLEARANCE FOR EXERCISE

Patient's name: _____

Address: _____

Date of birth: _____

☐ I ***do not*** wish to participate in the Fitness Program. Signature:_____

Physician's name: _____

Address: _____

Telephone number: _____

YES____ My patient _____ has no current unstable medical problems that are a contraindication to participating in an exercise or resistance-training program. I approve of and support his or her participation in this progressive strength, endurance, cardio, flexibility-training exercise program, and I have discussed the signs and symptoms that would make an exercise program unsafe. These symptoms are summarized as follows:

_____

_____

_____

NO____ My patient _____ is not eligible to participate in the exercise program due to his or her current medical status.

Please indicate any special recommendations or specific comments:

_____

_____

_____

_____ _____

Physician's signature Date