



## PHYSICIAN'S RELEASE FORM

Date: \_\_\_\_\_

Dear Physician:

Your patient, \_\_\_\_\_, wishes to start a personalized exercise program with Tracey MacDiarmid Personal Training. As a participant in this program, your patient will be instructed in proper exercise techniques working one-on-one with a Personal Trainer. The Personal Trainer will be certified and will follow the American College of Sports Medicine (ACSM) guidelines for developing and maintaining cardiorespiratory and muscular fitness in healthy adults (Med Sci Spts Exercise, 22:2, 1990, pp. 265-274). In short, the guidelines are as follows:

### Cardiorespiratory Fitness / Muscular Fitness

**Frequency:** 3-5 days/week & at least 2 days/week  
**Intensity:** 60-90% Max Heart Rate with moderate resistances  
**Duration:** 20-60 minutes  
**Mode of Activity:** Aerobic exercise & strength training of major muscles

Are there any medical factors in your patient's history or any medications that are currently being taken which would affect exercise programming or the patient's ability to participate in a non-medically supervised exercise program?

Please Check:           **YES**    **NO**

If yes, please list and explain.

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Please identify any recommendations or restrictions that are appropriate for your patient in an exercise program.

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My patient, \_\_\_\_\_, has my approval to begin an exercise program with Tracey MacDiarmid Personal Training with the recommendations or restrictions stated above.

Physician Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Office Ph: \_\_\_\_\_

Please fax this form to (703) 904-5586 or mail it to the address below.  
Thank you for your cooperation.

Tracey MacDiarmid, CAPT, OAT  
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