



Redefining Possibilities for the  
Spinal Cord Injury Community

## Physician's Clearance Form

Please return this form to:

Push to Walk, 6 North Corporate Drive, Riverdale, NJ 07457

Phone: 862-200-5848; Fax: 862-200-5976

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ Age \_\_\_\_\_

Patient's Address \_\_\_\_\_

Date of last physical examination \_\_\_\_\_

\_\_\_\_\_ This patient may participate fully in an intensive physical exercise program consisting of cardiovascular, strength, flexibility and load bearing training of both the upper and lower extremities without limitation.

\_\_\_\_\_ This patient may participate in an intensive physical exercise program with the following limitations and/or recommendations:

\_\_\_\_\_

Please include a brief description of any medical condition(s) that may affect her/his participation in an intensive exercise program:

\_\_\_\_\_

If this patient is on any medication that may affect the heart rate or the blood pressure to response to exercise (elevating or suppressing), please indicate:

I consider the above individual to be: \_\_\_\_\_ normal  
\_\_\_\_\_ cardiac patient  
\_\_\_\_\_ coronary heart disease  
\_\_\_\_\_ other (explain)

Please fill in the following information if available:

Blood Pressure \_\_\_\_\_

Glucose \_\_\_\_\_

Total serum cholesterol \_\_\_\_\_

HDL-C \_\_\_\_\_ LDL-C \_\_\_\_\_

Triglycerides \_\_\_\_\_

Physician's Name \_\_\_\_\_ Date \_\_\_\_\_

Physician's Signature \_\_\_\_\_

\*Note – this record must be stamped with a physician's official stamp or be accompanied by a typed letter on physician's letterhead, documenting that a medical evaluation has been performed on named client. THE PHYSICIAN'S CLEARANCE FORM WILL NOT BE ACCEPTED WITHOUT SUCH PROPER VERIFICATION.