Voluntary Physician Cover Letter

Physician Name: ____________________________
Hospital/Clinic Affiliation: __________________
Phone Number: _____________________________
Fax Number: ________________________________

Date: ________________

Dear Dr. _________________________________:

Your patient, ____________________________________________ , is interested in participating in the **Stay Strong, Stay Healthy Program**. This moderate-intensity, progressive exercise program includes strength and balance training and is designed to improve muscle strength, dynamic balance and flexibility.

This is an evidence-based exercise program designed especially for midlife and older adults. It was developed and researched by faculty at University of Missouri Extension. __Frontier Extension District Staff__ is/are implementing the program in Osage City, KS _______________________. Your patient will be required to provide informed consent prior to participation in this exercise program and is informed of the associated risks.

Please complete and sign the enclosed Physician Authorization Form. If you have any questions or would like to discuss your patient’s participation in the program in further detail, please call me at 785.448.6826; 785.828.4438.

Sincerely,

**Chelsea Richmond, Extension Agent**  
Nutrition, Food Safety, and Health

**Janae McNally, Extension Agent**  
Adult Development and Aging and Family Resource Management

K-State Research and Extension  
411 S Oak; PO Box 423  
Garnett, KS 66032  
785.448.6826; 785.448.6153 (fax)  
crichmon@ksu.edu

K-State Research and Extension  
128 W 15th; PO Box 400  
Lyndon, KS 66451  
785.828.4438  
jmnally@ksu.edu
Voluntary Physician Authorization Form

Patient’s Name: _______________________________  Birth Year: __________

☐ Yes, my patient can participate.

☐ Yes, my patient can participate with the following limitations:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

☐ No, my patient cannot participate at this time because of his or her medical conditions and health status.

Physician’s signature: ______________________________________________________

Print name: _______________________________  Date: _________________

Phone number: _______________________________  Fax: ___________________

This form may be given to the patient, OR sent to the course instructor at:

Chelsea Richmond  -- crichmon@ksu.edu; 785.448.6153 (fax)

Janae McNally  -- jmnally@ksu.edu

Please return this form by:  June 14, 2024

For instructor use. Valid for one year.