

**Stay Strong, Stay Healthy**



# Voluntary Physician Authorization Form

Patient's Name: \_\_\_\_\_ Birth Year: \_\_\_\_\_

Yes, my patient can participate.

Yes, my patient can participate with the following limitations:

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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:

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Please return this form by: \_\_\_\_\_

*For instructor use. Valid for one year.*



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**Agricultural Experiment Station and Cooperative Extension Service**  
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## 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. \_\_\_\_\_ is/are implementing the program in \_\_\_\_\_. 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 \_\_\_\_\_.

Sincerely,

\_\_\_\_\_



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