



The Journey Program®

Cancer Exercise Wellness Medical Clearance Form

Dear Physician:

_____ (print patient name) _____ (patient phone number), has applied to enroll in The Journey Program. Our program provides guided exercise programs for cancer patients who are newly diagnosed, undergoing treatment, in remission and cancer survivors two years post treatment. The program is held twice a week for 10 weeks.

A specific individualized exercise program is designed for each participant, depending on the clients' needs and abilities beginning with basic stretching, flexibility, and core strength exercises. Modified resistance training is progressively added to increase upper and lower body strength and bone density. The client's program is carefully monitored so that their abilities and needs are consistently re-evaluated.

If you know of any medical or other reasons why participation in our Cancer Exercise Wellness Program by the applicant would be unwise, please indicate on this form.

If you have any questions about the program, please do not hesitate to call Jean Mahoney, CPT, Cancer Exercise Specialist at 231-276-2494.

Report of Physician

_____ I APPROVE the applicant to participate in this program with NO restrictions.

_____ I APPROVE the applicant to participate in this program on a RESTRICTED basis. The applicant should not engage in the following activities:

_____ I DO NOT approve the applicant to participate in this program. Please include reasons, if appropriate:

Physician's Signature _____ Date _____

Address _____ Phone _____

please return signed document to Fyzical Therapy: Fax 231-932-9034

or for the Frankfort location, The Betsie Hosick Health and Fitness Center Fax 231-352-9663

The Journey Program is Sponsored by:

