Physician's Clearance

________________________________ (Participant's Name) has been examined by me and has my approval to participate in a progressive exercise program. I understand the physical and physiological stressors of a workout program and see no reason why the above named person should not participate.

________________________________M.D. __________________
(Physician's Signature) **(Date)**

Type of Activity	Approval	Recommendations
Cardiovascular		
Resistance Training		
Flexibility Training		

Any Other Physician Recommendations or Contraindications

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X Factor Wellness Solutions
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