

STATEMENT OF HEALTH STATUS
Calendar Year 2021

Name: _____

Address: _____

Date: _____

This is to certify that I have found the above-named person to be in good health and free of health problems that would prevent him/her from participating in light to moderate aerobic and strength physical activity program.

Physician Signature: _____

Address: _____

Phone Number: _____

This statement must be signed by a licensed physician or his/her authorized physician assistant or nurse practitioner.