CHARLIE BLACK, PT
RALPH TRUITT, PT, MPT, Cert. MDT

Aquafit PHYSICAL THERAPY

Physician Release Form

Please indicate below if there are any special precautions, limitations, restrictions or reasons why this participant should limit, (or decline) his/her participation in this program.

_____

I agree that the above named member may participate in the Aquafit Physical Therapy Fitness Program.

Physician's Name: _____

Physician's Phone: _____

Physician's Signature: _____ Date: _____

to complete the Diagnosis Verification Form (optional, depending on chapter's requirements)