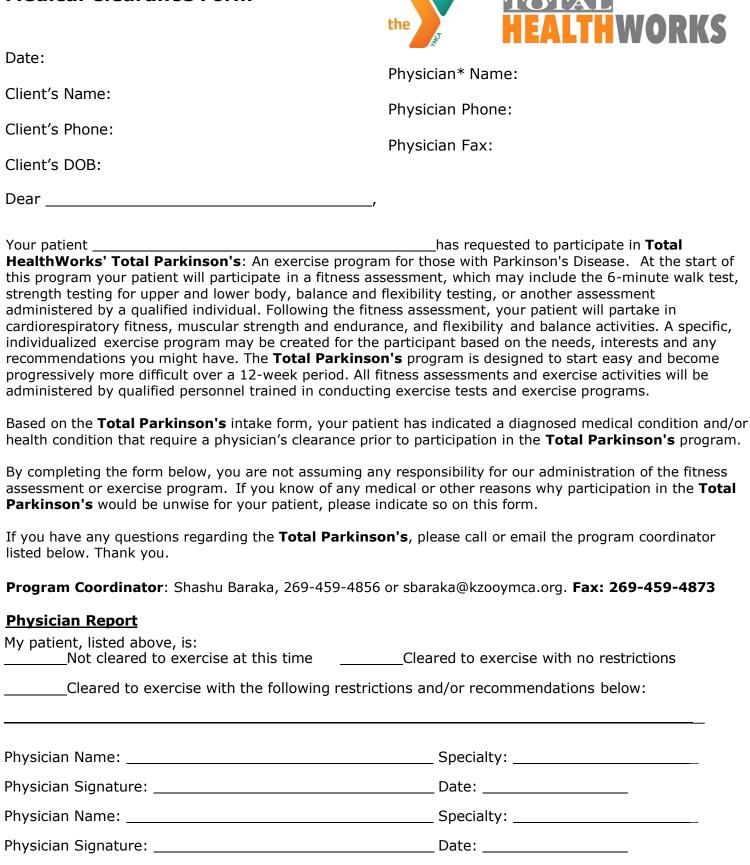
## **Medical Clearance Form**



Physician Signature: Date:

Physician Name: \_\_\_\_\_\_ Specialty: \_\_\_\_\_

<sup>\*</sup>You may need medical clearance from more than one physician. E.g. neurology, primary care.