

MEDICAL CLEARANCE FORM

Dear Doctor _____

Your patient _____ would like to participate in a Pedaling with Parkinson's indoor cycling program (PwP™) held at HealthFit – Powered by Sarasota Memorial.

The PwP™ exercise program will train your patient gradually increasing his/her aerobic capacity and muscle strength over several weeks. The goal is to aim for a target heart rate of 60%-80% of their maximum heart rate while pedaling a stationary bike at 80-90 revolutions (RPMs). The PwP™ exercise goal is derived from research that showed a 30% reduction in Parkinson's symptoms when the exercise protocol is followed and target heart rates and cadence (RPM) are reached. Therefore the PwP™ program involves vigorous exercise that is performed on a stationary bike in a supervised setting with certified instructors/trainers. Please complete the physician recommendation form below.

Please feel free to contact me at: _____ if you have questions.
Thank you in advance for your cooperation.

____ Patient may participate. I am not aware of any reason why this patient should not participate.

____ Patient may participate with the following limitations:

____ Patient may participate. However, patient is taking medications that will affect heart rate response to exercise (raises or lowers heart rate) please indicate specific medication(s):

____ Patient may not participate and should not participate at this time because:

My patient has my approval to participate in the Pedaling with Parkinson's™ (PwP™) program with the recommendations and/or restrictions stated above

Physician's Signature _____

Physician Print Name _____

Date _____

Please return Medical Clearance Form to:
HealthFit: Powered by Sarasota Memorial
5880 Rand Blvd. Suite 102
Sarasota, FL 34238
Phone: (941) 917-7000
FAX: (941) 917-7478