



Client # _____

Physical Fitness Statement & Letter of Medical Care Certification

Please verify care and return to: The Poverello Center, Inc.'s Live Well Center
2056 N Dixie hwy, Wilton Manors FL 33305
954-563-1299

Client _____ D.O.B _____

Phone _____

Street Address _____

City, State, Zip _____

Client Signature _____



NOTE!! The Following Physician's Physical Fitness Certification can be completed by the primary care physician or designated nursing staff.

This letter certifies that _____, named here and above, is currently my patient and was last seen in my office on ___ / ___ / ___ and IS _____ IS NOT _____ Physically Fit to participate in the exercise, massage, acupuncture, chiropractic, yoga and fitness Program(s).

Physician _____ Date _____
Print Name

Physician _____ Phone _____
Authorized Signature

Name of Agency/Hospital (if applicable) _____