Dear Doctor,

Your patient would like to attend our Can Do Multiple Sclerosis CAN DO® Program, an educational program for people with MS and their Support Partners. During the four-day program, they have the opportunity to participate in lectures, group discussions, experiential workshops, and a sub-maximal exercise session facilitated and supervised by our fitness staff.

The participant's rate of perceived exertion is measured on standard exercise equipment (exercise bike, treadmill, arm ergometer etc.). This exercise session is designed to provide each participant with a positive exercise experience while allowing him or her to identify his or her own individual and appropriate exercise intensity. It is utilized by our consultants in the development of individual exercise recommendations.

We are requesting your medical clearance before your patient participates in this sub-maximal exercise session and receives our carefully designated exercise recommendations. Please note any restrictions, sign the form and return it, along with any other relevant information, to Can Do MS. Since this session is sub-maximal, it is *not* intended to be a screen for possible cardiovascular pathology.

If you have any questions about the information you have been asked to provide about Can Do MS or the CAN DO Program, please do not hesitate to contact me.

Thank you very much for your time.

Regards,

Laura Coyne
Programs Manager
lcoyne@mscando.org
800-367-3101 ext 1275
970-926-1275
970-926-1295 Fax

**See next page for Medical Release Form.**

**Time Sensitive Document! Please email to lcoyne@mscando.org or fax to 970-926-1295.**

# MEDICAL RELEASE FOR PARTICIPATION

*Please use this form to provide your recommendations for your patient's participation in sub-maximal exercise sessions as described in the accompanying letter.*

**1. Patient Information:** (DOB_____________)

Name ______________________________

Address ____________________________

City ________________ State ___ Zip _____

Phone ______________________________

**Physician Information:**

Name ____________________________________

Address __________________________________

City _____________________ State ___ Zip ______

Phone ____________________________________

**2. Are there any medical factors in your patient's history or any medications that are currently being taken which would affect the sub-maximal exercise programming or the patient's ability to participate in a sub-maximal exercise program?** Please circle: Yes No

**If yes, please list and explain:** ______________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**3. Please identify any recommendations or restrictions that are appropriate for your patient in this exercise program:** ______________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**4. Release:** *(check one)*

☐ Patient **may participate** in sub-maximal exercise sessions **without any restrictions.**

☐ Patient **may participate** in sub-maximal exercise sessions **with restrictions** (*please note below).*

☐ Patient **may NOT participate** in sub-maximal exercise sessions *(please provide an explanation).*

**5. Additional Comments/Restrictions:** *(Please attach additional pages if needed)*______________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Physician's Signature ______________________________ Date ___________________

**Time Sensitive Document! Please email or fax to Laura Coyne: lcoyne@mscando.org or 970-926-1295**