



Date\_\_\_\_\_

Dear Doctor:

Your Patient, \_\_\_\_\_, wishes to start a personalized training program that will include resistant training, flexibility and strength exercises, balance movements and cardiovascular endurance.

If your patient is taking medications that will affect his or her heart rate response to exercise, please indicate the manner of the effect (raises or lowers).

Type of Medication:\_\_\_\_\_

Effect:\_\_\_\_\_

Please identify any recommendations or restrictions that are appropriate for your patient in this exercise program: \_\_\_\_\_

\_\_\_\_\_

Thank you for your attention to this matter.

Sincerely,

Brandi Millis  
TRAIN WITH BRANDI, LLC  
PO Box 22  
Wyncote, PA 19095  
215-740-8660

\_\_\_\_\_ has my approval to begin an exercise program with the recommendations or restrictions stated above.

Physician's Name (Please Print)\_\_\_\_\_

Physician's Signature\_\_\_\_\_ Date:\_\_\_\_\_

Phone:\_\_\_\_\_