Physician Name: ____________________________
Hospital/Clinic Affiliation: __________________________
Phone Number: __________________________
Fax Number: __________________________

Date: __________________________

Dear Dr. __________________________:

Your patient, __________________________, is interested in participating in the Stay Strong, Stay Healthy Program. This moderate-intensity, progressive exercise program includes strength and balance training and is designed to improve muscle strength, dynamic balance and flexibility.

This program is based upon the results of strength training studies in older adults conducted by scientists at the John Hancock Center for Physical Activity and Nutrition at the Gerald J. and Dorothy R. Friedman School of Nutrition Science and Policy at Tufts University in Boston, Mass. Scientists and exercise physiologists at Tufts University have designed this exercise program especially for midlife and older adults. __________________________ are implementing the program in __________________________. Your patient will be required to provide informed consent prior to participation in this exercise program.

Please complete and sign the enclosed Physician Authorization Form. If you have any questions or would like to discuss your patient’s participation in the program in further detail, please call me at __________________________.

Sincerely,

[Signature]

K-STATE Research and Extension

UNIVERSITY OF MISSOURI Extension
an equal opportunity/ADA institution
Voluntary Physician Authorization Form

Patient’s Name: ____________________________  Birth Year: __________

☐ Yes, my patient can participate.

☐ Yes, my patient can participate with the following limitations:

☐ No, my patient cannot participate at this time because of their medical
  conditions and health status.

Physician’s signature: ____________________________

Print name: ____________________________  Date: __________

Phone number: ____________________________  Fax: ____________________________

This form may be given to the patient, OR sent to the course instructor at:

Please return this form by: __________

For instructor use. Valid for one year.