

VERIFICATION OF DISABILITY

-----TO BE COMPLETED BY THE MEMBER-----

Members Name: _____

Member Number: _____ - _____ Phone Number: (____) _____

-----TO BE COMPLETED BY THE PHYSICIAN-----

Patient's Name: _____

Please fill out this form regarding your patient (listed above). Be aware that the purpose of this document is to allow your patient to alter the terms of a legally binding contract with a health club.

My patient's club use was affected on: ____ / ____ / ____ .

This condition: (check one)

1. Does not allow my patient to utilize a health club under any circumstances, or in any way.
2. Would not affect health club use.
3. Allows my patient limited use of a health club as explained below:

The duration of this condition: (check one)

1. Ended on: ____ / ____ / ____ .
2. Still persists, and will last for ____ (weeks / months / years) **from the onset** of the condition.
3. Still persists, and will be permanent. (circle one)

I certify that the patient listed above is my patient and is under my care. I also certify that a thorough physical examination and any necessary testing was done to make these conclusions regarding my patients disability. I understand that by making these representations I will make myself available for necessary testimony in a court of competent jurisdiction to verify that the above-referenced patient's condition is stated truthfully, and that any costs associated with such testimony will be incurred by the patient. **I also understand that if any of the above representations are found to be untrue that I could be found liable for damages and prosecuted to the full extent of the law.**

_____, MD
Medical Doctor's Signature

____ / ____ / ____
Date

_____, MD
Medical Doctor's name, printed

Medical License number (Required)

(____) _____
Medical Doctor's phone number

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Questions: 1-800-658-7727