

LOS OSOS FITNESS

PHYSICIAN'S APPROVAL FORM

_____ has medical approval to participate in fitness programs and in the use of exercise equipment at LOS OSOS FITNESS.

The following restrictions apply (if none, so state):

Physician's Signature: _____

Physician's Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Date: _____

Please **EMAIL** back to ***info@losososfitness.com***

For questions please call (805) 528-1190

1078 Los Osos Valley Road

Los Osos, CA 93402

ATTN: _____