Ho'ola Cancer Exercise Wellness Program
25 Maluniu Avenue
Suite #102-PMB 166
Kailua, HI 96734
http://www.cancerexercisewellness.org

Medical Clearance Form

Dear Doctor:

_____, has applied to enroll in the Ho'ola Cancer Exercise Wellness Program which will be conducted at the Castle Medical Center facilities, as an independent contractor provided service. Our program provides guided exercise programs for individuals undergoing treatment for cancer, for patients in remission and cancer survivors. The program is held twice a week for 10 weeks.

A specific individualized exercise program is designed for each participant, depending on the clients' needs and abilities beginning with basic stretching, flexibility, and core strength exercises. Modified resistance training is progressively added to increase upper and lower body strength and bone density. The client's program is carefully monitored so that their abilities and needs are consistently re-evaluated. All of our trainers are nationally certified, degreed and cancer exercise specialist certified.

If you know of any medical or other reasons why participation in a cancer exercise wellness program by the applicant would be unwise, please indicate on this form.

If you have any questions about the program, please do not hesitate to call Karen Merrill, M.S., AT.C, LMT at (808) 284-5150.

Report of Physician

_____ I APPROVE the applicant to participate in this program with NO restrictions.

_____ I APPROVE the applicant to participate in this program on a RESTRICTED basis. The applicant should not engage in the following activities:

_____

_____

_____ I DO NOT approve the applicant to participate in this program. Please include reasons, if appropriate:

_____

_____

Physician's Signature_____ Date_____

Address_____ Phone_____