Health Care Provider
Medical Release for Therapy/Program Participation

We are requesting approval for your patient

____
Patient Name (Please print)

to participate in exercise, massage, strength training and/or other fitness programs at OSF Healing Pathways Cancer Resource Center.
eld
____ May Participate

____ May **NOT** Participate

Please list any limitations or contraindications:
____
____
____
____

Physician or Health Care Provider **Signature Date**

____ __________________

____
(Please print physician name)

Please submit in person or by fax or mail to:

OSF Healing Pathways Cancer Resource Center
5668 E. State Street, Suite 2700
Rockford, Illinois 61108
Fax Number: 815/977-5513
Phone Number: 815/977-4123