



Lambda Cycling Foundation, Inc.

906 Duval Ct.
Ft Lauderdale, FL 33334

Medical Clearance Form

Please print this form and take it to your Physician's office for completion.

Patient Name: _____

Patient Participation Survey

YES **NO**

___ ___

May participate in the program with no restrictions.

___ ___

May participate in the program, but the following RESTRICTIONS ARE URGED:

___ ___

Should have a physical exam and a 12 lead stress test participation.

Please provide any additional information or recommendations that may be useful in prescribing and instituting a safe, effective, individualized exercise program for you patient.

Physician's Name (Type or Print) _____

Physician's Signature: _____ Date: _____