



# MEDICAL RELEASE FORM

DATE: \_\_\_\_\_

MEMBER # \_\_\_\_\_

Dear Medical Doctor:

\_\_\_\_\_ is a current member of Urban Active and has requested release from his/her agreement due to medical disability. Your patient must be unable to use a "substantial" portion of our club facilities or services for a predetermined amount of time as outlined below.

Since this agreement is a legal binding contract, Urban Active may require your patient to submit to a physical examination by a mutually agreeable medical doctor, at Urban Active's cost.

Using your professional opinion, please check from the following list, those facilities/services which your patient may not use and indicate a time in days that the member cannot use these equipment/services. Please attach a letter certifying your medical findings and certify that the above patient has a medical disability, which would prohibit this member from utilizing a substantial portion of our club's facility and or services.

EQUIPMENT (Check Each That Apply)	NUMBER OF DAYS UNABLE TO USE (Use numbers only)
_____ TREADMILLS	_____
_____ NON-IMPACT CARDIO EQUIPMENT	_____
_____ SELECTORIZED EQUIPMENT	_____
_____ FREE WEIGHTS	_____
_____ RECUMBENT BIKES	_____
_____ STAIRMASTER	_____
_____ LOW IMPACT AEROBICS	_____
_____ BODY PUMP CLASSES	_____
_____ WALKING	_____
_____ JOGGING	_____
_____ WEIGHT LIFTING	_____

Please return this letter to Urban Active, Member Support Department, and Attention: Cancellations, 1056 Wellington Way. Suite 200, Lexington, KY 40513. If you have any questions, please direct them to the Member Support Department at (859) 252-5993. Thank you for your cooperation and quick response.

The undersigned acknowledges and understands that Urban Active is relying on the information provided herein to make a decision on granting or denying a cancellation or freeze to the above named Urban Active member, or seek another medical opinion as to your answers. Each of the undersigned represents, warrants and certifies that the information provided herein is true, correct and complete and gives permission to communicate all findings on this form to Urban Active's preferred medical doctor for review.

\_\_\_\_\_  
MD Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
MD Printed Name

\_\_\_\_\_  
Office Phone Number

-----For office use only-----

Approved \_\_\_\_\_ Declined \_\_\_\_\_ By \_\_\_\_\_ Date \_\_\_\_\_ MST # \_\_\_\_\_