

## VERIFICATION OF DISABILITY

-----TO BE COMPLETED BY MEMBER-----

Member's Name \_\_\_\_\_ Member Number: \_\_\_\_\_

-----TO BE COMPLETED BY THE PHYSICIAN-----

Patient's Name \_\_\_\_\_

Please fill out this form regarding your patient listed above. Be aware that the purpose of this document is to allow your patient to alter the terms of a **legally binding contract** with the interval circuit training center, Workout Express. Interval circuit training is proven to help tone and firm a person's body while building cardiovascular endurance. Strengthening muscles provide joint stability and helps fight osteoporosis. Regular circuit training helps burn body fat and increase lean muscle. Workout Express uses hydraulic equipment which features dual shock absorbers **with no weight stacks**. The hydraulic equipment is based on adjustable air pressure, similar to water resistance in a pool. The equipment also features a "push-pull" resistance which allows for working opposing muscle groups and provides each member the opportunity to work at her own fitness level, significantly reducing the risk of injury. To improve the cardiovascular endurance of our members, we utilize low impact aerobics. High impact aerobics is not part of our system. We offer individual upper body, lower body and core stabilizing equipment to give members to flexibility to continue working out should they need to rest a specific area.

My patient's condition began on: \_\_\_\_/\_\_\_\_/\_\_\_\_.

As his/her Medical Doctor, I recommend my patient: (check one)

- Limit his/her workouts to Upper Body / Lower Body / Core (circle all that apply).  
The duration of this condition will last for \_\_\_\_ (days / weeks / months) **from the onset** of the condition  
*(Memberships can be frozen monthly, up to 3 months at a time. Subsequent Disability Forms must be completed for additional 3 month periods.)*

- Refrain from exercising for the rest of his/her life for the following reason(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I certify that the member listed above is my patient and is under my care. **I also certify that a thorough physical examination and any necessary testing was recently completed to make these conclusions regarding my patient's disability.** I understand that by making these representations I will make myself available for necessary testimony in a court of competent jurisdiction to verify that the above-referenced patient's condition is stated truthfully, and that any costs associated with such testimony will be incurred by the patient. I also understand that if any of the above representations are found to be untrue that I could be found liable for damages and prosecuted to the full extent of the law.

\_\_\_\_\_, MD  
Medical Doctor's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_, MD  
Medical Doctor's Name, Printed

\_\_\_\_\_  
Medical License Number (Required)

\_\_\_\_\_  
Medical Doctor's Phone Number

Mail, deliver or fax to: Workout Express, \_\_\_\_\_