FEDERAL OCCUPATIONAL HEALTH

HEALTH STATUS CHANGE NOTIFICATION FORM

Client Name _____ **Date**_____

Physician Name _____

Physician Address _____

_____

Physician Phone Number _____

Please describe the nature of the change in your health:

_____

_____

_____

Please list any new medications/ dose/ reason prescribed:

_____

_____

_____

Do you plan to continue your membership?	____	**Yes**	____	**No**	
Has your physician cleared you for exercise?	____	**Yes**	____	**No**	
Did your physician note any limitations?	____	**Yes**	____	**No**	
Change in Risk Stratification?	____	**Yes**	____	**No**	**(completed by staff)**
Medical clearance required before returning?	____	**Yes**	____	**No**	**(completed by staff)**

Client Signature _____ **Date** _____

Staff Signature _____ **Date** _____