

VERIFICATION OF DISABILITY

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

Member's Name: _____

Member Number: _____ - _____ Phone 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 a health club.

My patient's club use was affected on: ____/____/____ .

This condition: (check one)

1. Does not allow my patient to utilize a health club under any circumstances, or in any way.
2. Would not affect health club use.
3. Allows my patient limited use of a health club as explained below:

The duration of this condition: (check one)

1. Ended on: ____/____/____ .
2. Still persists, and will last for ____ (weeks/months/years) **from the onset** of the condition.
(circle one)
3. Still persists and will be permanent.

I certify that the patient listed above is my patient and is under my care. I also certify that a thorough physical examination and any necessary testing was done to make these conclusions regarding my patient's disability. I understand that by making these representations I will make myself available for any 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 to:
National Fitness
P.O. Box 497
Layton, UT 84041-0497

or Fax to:
(801) 825-3636

Questions: (800) 658-7727