

VERIFICATION OF DISABILITY

Member's Name: _____
Member Account: _____ - _____ **Phone #:** _____ - _____

I _____ authorize my physician to release information about my condition to Lady of America, Health Clubs of America or Ladies Workout Express. I also understand that this form is intended for verification purposes ONLY and the submission of the same does not represent an automatic cancellation of my membership agreement.

Member Signature: _____

.....**To be Completed by the Physician**

Please fill out this form regarding your patient (listed below). Be advised that the purpose of this document is to allow your patient to terminate a legally binding contract with a health club facility in accordance with state law.

Patient's Name: _____

My patient's condition began on ____/____/____.

This condition (check one):

- allows my patient limited use of a health club.
- does not allow my patient to utilize a health club under any circumstances.
- does not affect health club use.

Description of condition: _____

The duration of this condition (check one):

- still persists, and will last for ____ (weeks/months/years)
- still persists and is permanent.
- will not affect health club use

My patient may return to the health club on _____.

I certify that the patient listed above is my patient and under my care. I certify the truthfulness of the information contained above and that such information resulted from a thorough physical examination and all necessary evaluation. I agree to make myself available to testify in any legal proceeding as to the information contained herein. I also understand that if any of the above representations are found to be untrue, I may be subject to damages and prosecuted to the fullest extent of the law.

Physician's Signature

_____/_____/_____
Date

Physician's Printed Name

Medical License No.

Phone