DEREE FITNESS PROGRAM

MEDICAL CERTIFICATE FOR THE USE OF ATHLETIC FACILITIES

MEMBER'S INFORMATION

First Name:	
Last Name:	
Date of Birth:	

PATHOLOGIST, or CARDIOLOGIST (or PEDIATRICIAN for children)

Date of Examination:	
Doctor's Full Name:	
Specialty:	
I confirm that the above-mentioned individual is healthy and fit to exercise without restrictions. **YES** ☐ **NO** ☐	
Signature and Stamp	

DERMATOLOGIST (or PEDIATRICIAN for children)

Date of Examination:	
Doctor's Full Name:	
Specialty:	
I confirm that the above-mentioned individual do not suffer from any skin diseases. **YES** ☐ **NO** ☐	
Signature and Stamp	

The health certificates that are signed by the doctor more than 3 months prior to the date of submission will not be accepted.