Paralyzed Veterans of America – Wisconsin Chapter (PVA-WI)

InvestFit Program – Medical Clearance Form

SECTION 1 — PVA-WI LIFE MEMBER INFORMATION

Life Member Name: _____

PVA-WI Life Member Number (if known): _____

Date of Birth: ___ / ___ / _____

Phone: _____

Email: _____

Requested Fitness Equipment:

_____

_____

Intended Use or Fitness Goal:

_____

_____

SECTION 2 — MEDICAL PROVIDER INFORMATION

VA Primary Care Physician Name: _____

VA Clinic / Medical Center: _____

Phone: _____

Secure Fax (if applicable): _____

Email: _____

SECTION 3 — MEDICAL REVIEW (To Be Completed by VA PCP)

1. The veteran is medically able to safely use the requested fitness equipment:

☐ Yes ☐ No

If No, please explain:

_____

_____

2. Relevant medical conditions, considerations, or precautions:

_____

_____

_____

3. Recommended usage restrictions (if any):

_____

_____

4. Suggested alternative equipment (optional):

_____

_____

SECTION 4 — PROVIDER ATTESTATION

I attest that I am the Primary Care Physician for the above-named veteran within the VA healthcare system, and the information provided is accurate to the best of my knowledge. I approve this veteran's participation in the PVA-WI InvestFit program for use of the equipment listed above.

Physician Signature: _____

Printed Name: _____

Date: _____ /_____ /_____

VA Medical License / Credentials: _____

Stamp (if available): _____