Stay Strong, Stay Healthy

Voluntary Physician Cover Letter

Physician Name: _____

Hospital/Clinic Affiliation: _____

Phone Number: _____

Fax Number: _____

Date: _____

Dear Dr. _____:

Your patient, _____ , is interested in participating in the ***Stay Strong, Stay Healthy Program***. This moderate-intensity, progressive exercise program includes strength and balance training and is designed to improve muscle strength, dynamic balance and flexibility.

This is an evidence-based exercise program designed especially for midlife and older adults. It was developed and researched by faculty at University of Missouri Extension. Frontier Extension District Staff is/are implementing the program in Garnett, Kansas. Your patient will be required to provide informed consent prior to participation in this exercise program and is informed of the associated risks.

Please complete and sign the enclosed Physician Authorization Form. If you have any questions or would like to discuss your patient's participation in the program in further detail, please call me at 785.448.6826.

Sincerely,

Chelsea Richmond, Extension Agent
Nutrition, Food Safety, & Health
K-State Research and Extension
411 S Oak; PO Box 423
Garnett, KS 66032
785.448.6826; 785.448.6153 (fax)
crichmon@ksu.edu

Stay Strong, Stay Healthy

Voluntary Physician Authorization Form

Patient's Name: _____ Birth Year: _____

❑ Yes, my patient can participate.

❑ Yes, my patient can participate with the following limitations:

_____

_____

_____

❑ No, my patient cannot participate at this time because of his or her medical conditions and health status.

Physician's signature: _____

Print name: _____ Date: _____

Phone number: _____ Fax: _____

This form may be given to the patient, OR sent to the course instructor at:

Please return this form by: February 12, 2024

For instructor use. Valid for one year.