

**UFH/AFC Fitness
Physician Referral
Authorization**

Patient is cleared for unsupervised exercise. (Please check box if accurate.)

Precautions/limitations/special conditions we should be aware of:

Patient Information:

Name: _____

Phone: _____ Date of Birth: ____/____/____

I authorize Healthplex Sports Club to share monthly scan reports with Unite for HER in order to remain eligible for UFH funding. Initial here to acknowledge: _____

Physician/Medical Provider Information:

Name (print): _____

Signature: _____

Date: _____ Phone: _____

Offer includes 6-month individual membership to AFC>

- Be sure to mention you are a Unite for HER participant and bring identification to your first visit.
- You must use the facility at least four times a month in order to keep the membership active.
- If you have questions regarding this program, please contact Unite for HER at info@uniteforher.org.

**Please bring this completed form to your first visit in order to begin your membership.
We are looking forward to having you as a part of our AFC family.**



Dear Participant:

AFC is looking forward to having you join our family! Each Unite for HER participant will receive a six-month individual membership.

Please contact me if you have any questions about getting started.

Hope to see you soon!

Sincerely,