2650 Truxtun Road, Studio 201
San Diego, CA 92106

Participant Medical Clearance

Patient's Name: _____

Date of Birth: _____

Appointment Information

Date: _____ Time: _____

This is to certify that the above-named Patient was seen in our office by the:

☐ Physician ☐ Nurse ☐ Physician's Asst.

☐ Office Staff ☐ Nurse Practitioner ☐ Other

Patient may return as a participant with DanzArts without limitation:

☐ Today ☐ Tomorrow ☐ On _____ _____
(Day) *(Date)*

Physician's Name: _____

Address: _____

_____

Phone Number: _____

_____ _____
Physician's Signature Date