EquiCenter
Where healing comes naturally

Physician's Clearance for Equestrian Activities

Patient Information

- Name _____
- Date of Birth:_____

Occurrence/Injury/Surgery Information

Occurrence ☐ Injury ☐ Surgery ☐

Type: _____

Description: _____

I have reviewed the patient's medical history and post-surgical recovery. Based on my professional judgment, I am releasing this patient to participate in equestrian activities with the following conditions (if applicable):

☐ No restrictions.
☐ Restricted activities as noted and date of return to normal equestrian activities:

_____

_____

_____

Printed Name:_____ Title:_____
Signature: _____ Date:_____
License/UPIN Number:_____

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