DEPARTMENT OF DEFENSE
DiLorenzo TRICARE Health Clinic
5801 Army Pentagon
Washington, DC 20310-5801

Pentagon Fit To Win
Health Promotion Program

Dear Doctor:

_____ is a participant in the Fit To Win program, a large-scale health promotion program. Your patient has undergone a health risk appraisal and now wishes to enroll in the fitness and exercise conditioning portions of the program. The fitness testing involves aerobic capacity testing for cardio-respiratory fitness, body composition analysis, flexibility test, muscular strength and endurance tests. The aerobic capacity tests can include sub-maximal cycle testing, sub-maximal walking test, sub-maximal jogging test, or **maximal cardio-respiratory testing for low risk individuals.** The results of these tests, combined with your recommendations, will be used to develop a specific exercise plan for your patient. Qualified personnel trained in conducting exercise tests and exercise programs will administer all fitness tests and exercise programs.

By completing the form on the back however, you are not assuming any responsibility for our administration of the fitness test and/or exercise program. If you know of any medical or other reasons why participation in the fitness testing or exercise programs by the participant would be unwise, please indicate so on the form.

The following conditions/problems were identified during the health risk assessment. These may impact on your patient's ability to exercise:

_____
_____
_____
_____
_____
_____

Please address them in your comments.

If you have any questions, please contact our office personnel at (703) 692-8898. Your support is essential to the success of our program and is sincerely appreciated.

Healthfully Yours,

Pentagon Fit To Win Staff

**REPORT OF PHYSICIAN**

_____I know of no reason why my patient may not participate.

_____I recommend my patient for the maximal cardio-respiratory test
**(NOTE: Maximal tests are for evaluating aerobic fitness only, not for diagnosis; hence ECG IS NOT USED NOR is a physician present during testing)**

_____I recommend my patient perform ONLY the sub-maximal cardio-respiratory test

_____I believe my patient can participate, but urge caution...

_____
_____
_____
_____
_____

_____My patient should not engage in the following activities:

_____
_____
_____
_____
_____

_____I recommend that my patient not participate.

Comments:

Physician Signature & Stamp _____

Date _____ Address _____

City & State _____ Zip _____

Phone _____