

**“TWINGES IN THE HINGES”
PHYSICIAN CONSENT FORM**

(This form must be completed prior to class session - PLEASE PRINT)

PATIENT NAME: _____

ARTHRITIS CONDITION

The above patient has my approval to participate in the Arthritis Pool Class Program, “Twinges in the Hinges,” offered by Community Medical Group of Riverside, Inc.

The following information and limitation(s) should be noted by the instructor of the Pool Class:

PHYSICIAN NAME _____

ADDRESS _____

CITY/STATE/ZIP _____

PHONE NUMBER _____