Athlete directions: This form must be completed by the attending physician or medical specialist. One copy must be returned to the Athletic Training Staff before the athlete can be returned to participation.

Athlete’s Name_________________________________________ Date of Visit____________________
Nature of the Athlete’s Injury/illness (per ATC) ______________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
ATC requesting referral_________________________________   Phone #_________________________

Evaluation (to be completed by physician only: MD, DO, podiatrist, dentist, NP, etc.): ______________
___________________________________________________________________________________
___________________________________________________________________________________

Recommended Rx/Procedures: _____________________________________________________________
___________________________________________________________________________________

Recommended Activity:
___Full Contact/Practice   ___Remedial Exercise/No Practice
___Non Contact/Vigorous Practice   ___Complete Rest/No Practice
___Non Contact/Light Practice   ___Other: See Below

Describe any specific limitations:  _________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

Follow up requested?  ___No  ___Yes

Physician’s Name (print)________________________________    Phone #________________________
Physician’s Signature___________________________________   Date__________________