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**Special Medical Request**

Name: \_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail: \_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Seminar Date: \_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Seminar Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Name: \_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1) Please indicate the accommodations that you are requesting (i.e. special seating, electrical outlet access, etc.) and the reasons for your request.

2) If you are requesting special accommodations for individual circumstances other than a medical condition, please explain the reasons for your request. These requests will be confidentially reviewed by a member of The Aasgaard Company.

Authorization for Release of Confidential Information:

I hereby give my permission for the release of my personal medical information, which verifies the existence of a severe and chronic medical condition, to The Aasgaard Company and appropriate personnel form the Starting Strength Seminar staff.

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Signature Date

For Office Use Only

Date Received: \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_ Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Reviewed: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_ Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments: