



Progressive Fitness, LLP

EMERGENCY MEDICAL AUTHORIZATION

I/We hereby give consent for (1) the administration of any treatment deemed necessary by:
My preferred physician Dr. _____ or any of his/her associates.
My preferred dentist Dr. _____, or any of his/her associates, or in the event
the appropriate preferred practitioner is not available, by another licensed, qualified physician or dentist;
and (2) the transfer to: _____ Hospital, the preferred hospital, or any hospital
reasonably accessible.

Major Surgery

This authorization does not cover non-emergency major surgery unless the medical opinions of two other licensed
physicians or dentists concurring in the necessity for such surgery are obtained prior to the performance of such
surgery, defining such period for non-emergency surgery as 24 hours.

Medical Data

The following is needed by any hospital or practitioner not having access to my medical history:

Allergies: _____

Medication being taken: _____

Physical impairments: _____

Other pertinent facts to which physician should be alerted: _____

Medical insurance coverage: _____

Emergency contact name and phone: _____ Relationship: _____

In the event the above emergency contact cannot be reached, please contact: _____

DATE

PRINTED NAME

SIGNATURE