



**Weight Management Program  
Physician Information Letter  
(Optional)**

Thank you for choosing the Solutions Weight Management Program for Everyday Living.

This is truly one of the greatest decisions you will make towards a new and improved healthy lifestyle! We would be happy to provide a summary report identifying your improvements from the beginning to the completion of this great journey to change.

If you would like the Solutions Program to provide a summary report to your family physician please sign below.

\_\_\_\_\_  
Name of Participant (Please print) \_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Participant

Physician Name \_\_\_\_\_  
Physician Full Address \_\_\_\_\_  
Physician Office Phone Number \_\_\_\_\_  
Physician Fax Number \_\_\_\_\_

\_\_\_\_\_  
**Please read and sign below:**

The Solutions Weight Management Program will not be responsible for providing any additional health care other than the goals established for weight loss. If you require any other health related assistance you will need to contact your family physician.

\_\_\_\_\_  
Signature of Participant \_\_\_\_\_  
Date

Signature verifies the above information has been read.