

Weston's Wellness Center

"A Different Kind



of Health Center."

"Putting Your Health In Our Hands."

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Medical Clearance Form (MCF)

Date: _____

Dr. _____

Dear _____

Mr. _____ of _____ N.J. has requested our services in a program of Food Evaluation and General Nutritional Healthcare Services. Since our services personalize the healing modality to the needs of each individual with methods of nutritional health counseling and education with non-invasive wellness measures. We require a statement that there are no medical / psychological contraindications to prevent us from proceeding with our programs.

The programs will be conducted by Dr. F. James Weston, N.D., Ph.D. a Traditional Naturopath. If you agree that there are no contradictions in this case, please sign below.

Physician's Signature Required: ✕ _____

If you wish to discuss this, I shall be happy to do so. I shall keep you informed as to your patients progress.

Sincerely,

A handwritten signature in cursive script that reads "Dr. F. James Weston".

Dr. F. James Weston, N.D., Ph.D.