

Dear Physician,

Please help us by assessing your patient's eligibility to participate in the **Parkinson Wellness Recovery | PWR! Retreat** May 25–31<sup>st</sup>, 2025. The signed Medical Release (see reverse) is required to participate in Retreat exercise programs. PWR! will also conduct its own screening interviews.

The PWR! Retreat is a one-week intensive exercise and enrichment program for persons with Parkinson Disease (PD). The Retreat consists of daily exercise programs including low and/or high intensity aerobic and PD-specific functional skill training. PD-specific exercises include the practice of functional movements that have been shown by research to improve gait, balance, agility, strength, and functional capabilities in people with PD. Daily cardiovascular training may include treadmills, pole walking, stationary bicycles, rowing, and more. The program may also offer enrichment activities such as tai chi, yoga, and dance. Depending on a person's tolerance, up to four (4) hours of exercise programming per day will be available.

PWR! Retreat exercise programs are informed by research and based on the published research of Becky Farley, PhD, MS, PT, the Chief Scientific Officer of Parkinson Wellness Recovery.

Retreat programs are not medically supervised. The class instructors are trained PD-exercise specialists, who in their professional lives are physical, occupational, and speech therapists, and exercise professionals.

If you have any questions, please contact us at (520) 591-5346 or [info@pwr4life.org](mailto:info@pwr4life.org).

Thank you for your assistance,

Dr. Becky Farley  
Chief Scientific Officer  
Parkinson Wellness Recovery | PWR!



Retreat Applicant  
Medical Release  
Form to be completed by Physician

Applicant Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Please print full name

I. Please indicate by an "X" where your patient's current capabilities fall on a continuum.

a. Cognitive Impairment

None Mild Mod Severe

b. Fall Risk

None Mild Mod Severe

c. Limitations on Physical Activity and Endurance

None Mild Mod Severe

II. **Restrictions & Recommendations:** Please specify any other autonomic issues or comorbidities that may affect your patient's exercise tolerance, safety, or ability to follow instructions and work in small group exercise classes.

III. My patient may participate in the PWR! Retreat program. Yes \_\_\_\_\_ No \_\_\_\_\_

Physician Name (print) \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_