Alabama Board of Athletic Trainers

Physician/Athletic Trainer Protocol Consent Form

Please print or type all information, except where a Signature is designated.

Athletic Trainer: _____

Team/Organization: _____

(PRINT or TYPE Physician's Name Below)

I, _____, M.D./D.O. (select one), as team physician/consulting physician, hereby authorize the above-named individual to act in my behalf during my absence. This individual shall perform activities detailed in the Licensed Athletic Trainer Protocol, approved by the Alabama Board of Athletic Trainers and the State Board of Medical Examiners. Such authority shall include the following areas:

I – Prevention II – Recognition & Evaluation III – Management, Treatment, Disposition

IV – Rehabilitation V – Organization & Administration VI – Education & Counseling

In addition, I authorize this individual to assist or carry out any other instructions or procedures that I feel are warranted or necessary in the practice of athletic training.

Physician's Information	**Athletic Trainer's Information**
_____	_____
Team/Consulting Physician Signature	Athletic Trainer's Signature
_____	_____
Physician's Address	Business Address
_____	_____
City, State, Zip Code	City, State, Zip Code
_____	_____
Business Telephone Number	Business Telephone Number