CLEVELAND-CLIFFS INC.
Cleveland
3060 Eggers Ave., Cleveland, OH 44105
P 216.429.6000 clevelandcliffs.com

Dear Medical Provider:

Your patient/our employee (please print name) _____
wishes to join a gym or fitness center to begin an unsupervised fitness program.

Cleveland Cliffs - Cleveland Works **("the Company")** will reimburse the employee up to $360 per year for gym membership fees as long as he/she consults his/her physician with regard to his/her participation in a fitness program.

Please discuss with your patient any recommendations or restrictions you may have with regard to his/her fitness program. Please understand that the Company is only requesting that you discuss these issues with your patient; it is not requesting that you provide or otherwise share this information with the Company. By signing this form below you attest that you have discussed your recommendations with your patient.

Medical Provider's Signature	MD, DO, PA, NP	Date
Medical Provider's Name (print)	Phone	Fax
Address	City	State & Zip
Patient/Employee Signature	Phone	Date
Address	City	State & Zip