

WHM / Cancer Pilot Study

Medical Clearance Form

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This form documents medical authorization for your patient to enroll in the WHM/Cancer Pilot Study, an independent 16-week open science feasibility study of the Wim Hof Method (controlled breathing and gradual cold exposure) in adults living with cancer. *The study is non-interventional with respect to oncologic care* and is conducted remotely from the participant's home. Your signature confirms that, in your medical judgment, the patient is suitable to participate.

PATIENT INFORMATION

Patient name		Date of birth	
Cancer type & stage		Current / recent treatment	
Patient phone		Patient email	

WHAT THE PATIENT WILL DO

Over 16 weeks, with a follow-up at week 20, the participant will:

- Practice controlled breathing 10–15 minutes per day, 5+ days per week (paced breathing with short breath holds, 3–4 rounds)
- Use gradual cold exposure: a 15–30 second cold finish to a shower, progressing to 1–3 minutes over the protocol
- Optionally use cold-water immersion after week 4 (not permitted during active chemotherapy)
- Provide periodic finger-prick blood markers (hs-CRP, IL-6, glucose), wearable data, weekly surveys, and brief daily logs

PHYSICIAN ATTESTATION

I have reviewed the activities above. To the best of my medical judgment, my patient is suitable to participate, and **does not have any of the following**:

- Serious or unstable cardiovascular disease (recent MI, severe arrhythmia, uncontrolled hypertension)
- Stroke or TIA within the past 12 months
- Active epilepsy or recurrent seizures
- Severe psychiatric illness, including active psychosis or self-harm risk
- Pregnancy
- Severe anaemia, severe immune suppression, or severe respiratory compromise
- Any other condition I judge to make breath-hold practice or cold exposure unsafe for this patient
- I will notify the study team if my patient's clinical status materially changes during the study period.

Physician signature

Date

Printed name

Credentials & specialty (e.g., MD, oncology)

Practice / institution

Practice phone

Practice email

NPI / license # (if applicable)

Patient: return this signed form via the secure upload at coldtherapy.acoer.com · Questions: study@acoer.com

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