medical certificate

Issued for (Wrestler):

|  |  |  |  |
| --- | --- | --- | --- |
| First Name: |  | Last Name: |  |
| Style (FS/GR/WW) |  | Weight Class: |  |
| Province: |  | Date of Birth: |  |

I, the undersigned, Doctor,

|  |  |
| --- | --- |
| Name (First name, last name): |  |
| Medical Specialty: |  |
| Address: |  |
| Email: |  |

Certify that I have examined the Wrestler designated here above on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

 (dd/mm/yyyy)

I certify that this Wrestler has no medical contraindication to compete in the sport of Wrestling in any Wrestling Canada Lutte sanctioned events from the date of examination mentioned above. I certify that the information provided in this certificate is accurate. This certificate is done on request by the above-mentioned wrestler for the appropriate legal purposes.

Date, place, doctor’s signature and stamp: