# 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:**