#7 - 5370 Canotek Rd. • Ottawa, ON K1J 9E6 • Tel: 613.748.5686 • Fax: 613.748.5756

WRESTLING.CA

INABILITY TO PARTICIPATE MEDICAL FORM

Athlete Name:	
Athlete Address:	
Diagnosis:	
History of present Illness/Injury:	
Physical Exam findings (include date of assessment):	
Investigations (Include dates and results):	
Onset of disability:	
Anticipated duration:	
Name of examining physician:	
Address:	
Phone number:	
Signature:	Date:
Reviewed by WCL physician (please circle): Y N	

Please forward the signed form to the High Performance Manager. Please note that WCL may request a medical examination by a WCL designated physician.