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: