



**MEDICAL CERTIFICATE  
VALID FOR 2023**

Issued for (Athlete):

<b>Last Name:</b>	_____	<b>First Name:</b>	_____
<b>Style (FS/GR/WW)</b>	_____	<b>Weight Class:</b>	_____
<b>Province:</b>	_____	<b>Date of Birth:</b>	_____

I, the undersigned, Doctor,  
**Name (First name, last name):**

**Medical Specialty:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Email:** \_\_\_\_\_

Certify that I have examined the Athlete designated here above on \_\_\_\_\_.  
(dd/mm/yyyy)

I certify that this Athlete has no medical contraindication to compete in the sport of Wrestling in any Wrestling Canada Lutte (WCL) sanctioned events, in any of the age categories he / she is allowed to as per WCL rules, 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 Athlete for the appropriate legal purposes.

**Date, place, doctor's signature and stamp:**

