MEDICAL CERTIFICATE
VALID FOR 2025

Issued for (Athlete):

Last Name:		**First 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 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: