

I, the undersigned, Doctor : _____
Address : _____
Country : _____
Phone : _____
E-mail : _____

Confirm that I have examined, _____ (Full Name of Wrestler)
born on _____ (yyyy/mm/dd) and being 15 years old , and can confirm that he/she is
fit to participate in the Cadet Age Category ie. 16 – 17 Years Old.

Date
(Day/Month/Year)

Doctor's Signature

Doctor's Stamp