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 17 years old, and can confirm that he/she is

fit to participate in the Junior Age Category ie. 18 – 20 Years.

_____ _____

Date
(Day/Month/Year)

Doctor's Signature

Doctor's Stamp