

VETERAN MEDICAL CERTIFICATE

Article 5.1 of the General Regulations for the World Championships Veteran provides:

“Each wrestler shall pass a medical examination in his own country, one week before the competition start date. A UWW Veteran Medical Certificate should be filled and signed by a certified doctor. This form must be delivered to UWW doctor of the competition at the pre-weighing medical examination”.

UWW EVENT

Competitions:

Place / Date:

WRESTLER

Surname: First Name:

Date of Birth (Day/Month/Year): / / Sex: Male Female

Nationality:

Address:

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E-mail: Phone Number:

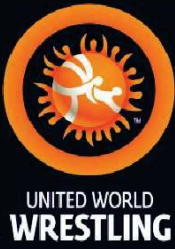
MEDICAL ASSESSMENT SUMMARIES

1. General Examination:

A- Medical History:

Normal Abnormal - Please specify:

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B- Routine Lab Tests:

Hemoglobin, Hematocrit, Erythrocytes, Thrombocytes, Leukocytes, C-reactive Protein, Glucose, Creatinine, Uric Acid, Triglycerides, Cholesterol (total, LDL, HDL), Creatine phosphokinase, Sodium, Potassium, Calcium, Phosphor, Urine Analysis

Normal Abnormal - Please specify:

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C- Skin Inspection:

Normal Abnormal - Please specify:

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D- General Health:

Normal Eligible to wrestle with considerations Non-eligible to compete

Please specify:

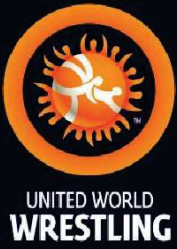
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Examining Doctor:

Surname & Name: Date:

Address:

Signature:



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2. Cardiovascular Examination

Physical examination, Chest x-ray, Heart rate & rhythm, Blood pressure, Electrocardiography, Echocardiography

- Normal Eligible to wrestle with considerations Non-eligible to compete

Please specify:

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Examining Doctor:

Surname & Name: Date:

Address:

Signature:

3. Orthopedic Examination

Spine (cervical, thoracic, lumbar), Shoulder, Arm, Elbow, Forearm, Wrist, Hand, Fingers, Hip, Thigh, Knee, Lower leg, Ankle & Foot

- Normal Eligible to wrestle with considerations Non-eligible to compete

Please specify:

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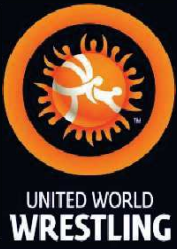
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Examining Doctor:

Surname & Name: Date:

Address:

Signature:



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Medical Certification

I certify that this wrestler:

- Has no apparent contraindication to practice wrestling at competitive level.
- Is not recommended to practice wrestling at competitive level.

Normal Eligible to wrestle with considerations Non-eligible to compete - Please specify:

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Certifying Doctor:

Surname & Name: Date:

Medical Registration Number:

Address:

Phone Number: Fax Number:

E-mail:

Signature & Stamp:

UWW Doctor Approval

- Medical Certificate Approved.
- Medical Certificate is not approved.

Surname & Name: Date:

Signature: