

# 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: .....

E-mail: ..... Phone Number: .....

## MEDICAL ASSESSMENT SUMMARIES

### 1. General Examination:

#### A- Medical History:

☐ Normal ☐ Abnormal - Please specify:

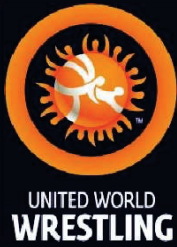
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## B- Routine Lab Tests:

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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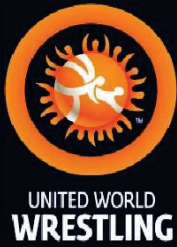
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## Examining Doctor:

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:

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## 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

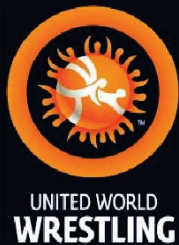
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Examining Doctor:

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:

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## UWW Doctor Approval

☐ Medical Certificate Approved.

☐ Medical Certificate is not approved.

Surname & Name: ..... Date: .....

Signature: