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:

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

Please specify: .....

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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: