*To be completed by a* ***MEDICAL PRACTITIONER***

***NOTE:*** *This form must be received by the Combat Sports Unit* ***within 14 days*** *of being completed and signed. Certificates of fitness over 14 days old will NOT be accepted.*

Contestant’s full name: 1

Date of Birth: 2 / /

Address: 3

Telephone: 4 Mobile: 5

Email: 6

Knock out or concussion within the previous 12 months? 7 **YES / NO**

8 If YES, list approximate dates for each:

**CERTIFICATION OF FITNESS**

I, 9 certify that the above-named contestant is

 *name of medical practitioner*

10 **FIT / UNFIT** compete in professional contests *(circle as appropriate).*

**CONFIRMATION OF CONTESTANT’S IDENTITY:**

I confirm I sighted a driver’s licence or 11 as photographic proof of the

 *insert other form of identification (e.g. passport)*

identity of 12 whose fitness is certified above.

 *name of contestant*

13 14 Date: / /

***Medical Practitioner’s signature***

15 Name:

16 AHPRA Reg No:

AFFIX STAMP

17 Address:

18 Telephone:

**PLEASE ENSURE ALL 18 FIELDS ARE COMPLETED OR THE FORM WILL BE REJECTED**