MEDICAL CLEARANCE FORM

ATHLETE INFORMATION

_____ _____ ____
LAST NAME FIRST NAME MI

____ / ____ / ____
DATE OF BIRTH

MEDICAL CLEARANCE TO BE SIGNED BY PHYSICIAN (MUST BE MD OR DO)

I hereby attest the above-named individual to be in good physical health with no observed pre-existing conditions or abnormalities that would prevent his/her ability to compete in a mixed martial arts event.

_____ _____
LICENSED PHYSICIAN PRINTED NAME (**MD** OR **DO**) PHYSICIAN LICENSE NUMBER

_____
ADDRESS

_____
PHONE NUMBER

_____ _____
PHYSICIAN'S SIGNATURE DATE

Certification must be dated within 180 days preceding the date of the event to be valid.

SEND TO: GLOBAL COMBAT ALLIANCE

FAX # (804) 441-9037 **EMAIL:** info@gcafights.com

WEBSITE: www.gcafights.com
ADDRESS: 6415 Jahnke Road, Richmond, VA 23225 **TELEPHONE**: (804) 928-3490