Kentucky Boxing and Wrestling Commission

500 Mero St, 218NC

Frankfort, Ky 40601



Phone: (502) 564-0085

Fax: (502) 696-3938

Email: kbwc@ky.gov

www.kbwc.ky.gov

MEDICAL RELEASE FORM

Physician's office must fax or mail this form to KBWC office

	D.	DATE OF EXAM	
NAME	FIRST	MIDDLE	
		WIBBLE	
TELEPHONE #	DATE OF BIRTH	DATE OF INJURY	
Being examined for the following		s and body part/area affected)	
Following examination, it is my r	medical opinion that he or she:		
Is unable to return to con Return appointment scheduled t	npetition until further notice. for		
	(Date)		
May return to training on		·	
	(Date)		
May return to full particip	ation of Boxing/Wrestling/MMA on	·	
Restrictions rehabilitation treat	ment:	(Date)	
restrictions, renabilitation, treat	mont.		
I attest that I do not have a profess	ional relationship with, nor financial intere	est in the earnings of this individual.	
(PRINT NAME OF EXAMINING PHYSICIAN	N) (PHYSICIAN'S LICENS	SE NUMBER)	
	· · · · · · · · · · · · · · · · · · ·	,	
(SIGNATURE OF EXAMINING PHYSICIAN	I) (ADDRESS OF PHYSI	ICIAN)	
OFFICE STAMP	(TELEPHONE NUMBE	ER OF PHYSICIAN)	