

Report of Medical Examination

World Police and Fire Games Federation

Part 1. ATHLETE INFORMATION

Surname	Given Name	Middle Name		
<input type="text"/>				
Address		Apt. Number	Gender	
<input type="text"/>		<input type="text"/>	<input type="checkbox"/> Male	<input type="checkbox"/> Female
City	State	<input type="text"/>		
Country		Postal Code	Home/Mobile Number	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Date of Birth			<input type="text"/>	
<input type="text"/>	<input type="text"/>		<input type="text"/>	
Email Address	<input type="text"/>			
<input type="text"/>				

Part 2. ATHLETE CERTIFICATION

I certify that this Report of Medical Examination is true to the best of my knowledge. I understand the purpose of this medical exam, and I certify that the required examinations have been completed. If it is determined that I willfully misrepresented a material fact or provided false/altered information or documents with regard to my medical exam, I understand that my eligibility to compete may be revoked and disciplinary action may result.

Signature
Date of Signature

Part 3. SUMMARY OF MEDICAL EXAMINATION

Date of Physical Exam

Satisfactory

Unsatisfactory

Date of Follow-up Physical Exam

Satisfactory

Unsatisfactory

Physician Remarks:

Part 4. PHYSICIAN CERTIFICATION

I certify that I am a physician designated to examine applicants seeking to compete in the World Police and Fire Games. I have a currently valid and unrestricted license to practice medicine in the state or country where I am performing medical examinations unless otherwise exempted. I performed this examination of the athlete listed above, after having made every reasonable effort to verify that the person whom I examined is in fact the person listed in Part 1 of this document. I performed the examination in accordance with standards that govern my license and I certify that all the information provided by me on this form is true and correct to the best of my knowledge, and belief.

Physician Signature

Date of Signature

Last Name

First Name

Middle Name

Name of Medical Practice, Facility or Health Department

Address

City

State

Country

Postal Code

Phone Number

Email Address

Physician Stamp (If Available)

Part 5. COMPETITOR INSTRUCTIONS

If this form is completed prior to six (6) weeks before Opening Day of Games, please mail or fax the completed form to World Police & Fire Games Federation at the following address:

World Police and Fire Games Federation
7944 Convoy Court, San Diego, CA 92111
Email: 4info@cpaf.org

If this form is not completed six (6) weeks before Opening Day, this exam form must be brought with you when you report to Host Registration. No exceptions.

**ALWAYS MAKE A COPY OF THE EXAM FOR YOUR RECORDS AND
KEEP ONE WITH YOU AS A BACK-UP.**