KENTUCKY BOXING AND WRESTLING COMMISSION

656 Chamberlin Avenue, Suite B,
Frankfort, Kentucky 40601

Email: KBWC@ky.gov
Phone: (502) 564-0085
Fax: (502) 696-3938

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

DATE OF EXAM _____

NAME _____
LAST FIRST MIDDLE

CURRENT ADDRESS _____

TELEPHONE # _____DATE OF BIRTH _____ DATE OF INJURY_____

Being examined for the following injury/illness:_____.
(Injury/illness and body part/area affected)

Following examination, it is my medical opinion that he or she:

_____ Is unable to return to competition until further notice.
Return appointment scheduled for _____.
(Date)

_____ May return to training on _____.
(Date)

_____ May return to full participation of Boxing/Wrestling/MMA on _____.
(Date)

Restrictions, rehabilitation, treatment:_____

_____

_____

_____

I attest that I do not have a professional relationship with, nor financial interest in the earnings of this individual.

_____ _____
(PRINT NAME OF EXAMINING PHYSICIAN) (PHYSICIAN'S LICENSE NUMBER)

_____ _____
(SIGNATURE OF EXAMINING PHYSICIAN) (ADDRESS OF PHYSICIAN)

_____
(TELEPHONE NUMBER OF PHYSICIAN)

OFFICE STAMP