

2023 Australian Kung Fu Wushu Championships



Certificate of Fitness (Sanda Full Contact)

CONTESTANT DETAILS

Contestant Name:				
Address:				
		State:	Postcode:	Phone:
DOB:	Age:	Sex: M / F	Height (cm):	Weight (kg):
Training:	Amateur (years):		Professional (years):	

MEDICAL PRACTITIONERS DECLARATION

Medical Practitioner's Name:			
Practice Address:			
Medical Registration Number:	State:	Postcode:	Phone:
I declare the contestant whom I identified from: (select one)			
<input type="checkbox"/> Photo Driver's License No: _____ Or			
<input type="checkbox"/> Photo Passport No: _____ Country of Issue: _____ Or			
<input type="checkbox"/> Other (please specify) _____			
in my opinion, and after taking the required medical assessments, is physically FIT to compete in Combat Sports Contests			
Comments (if applicable):			
Medical Practitioner's Signature:			Date:
Medical Practitioner's Stamp (if applicable):			

2019 Australian Kung Fu Wushu Championships



Serology Report (Sanda Full Contact)

**A copy of all three test results must accompany this form **

CONTESTANT DETAILS

Contestant Name:				
Address:				
		State:	Postcode:	Phone:
DOB:	Age:	Sex: M / F	Height (cm):	Weight (kg):

MEDICAL PRACTITIONERS DECLARATION

Medical Practitioner's Name:					
Practice Address:					
Medical Registration Number:		State:	Postcode:	Phone:	
I certify i have sighted the results of blood testing of the Contestant				Date of Tests:	
Is there evidence that the Contestant's blood is infected with the following virus?					
HIV	YES / NO	Hepatitis B	YES / NO	Hepatitis C	YES / NO
I declare the contestant whom I identified from: (select one)					
<input type="checkbox"/> Photo Driver's License No: _____ Or <input type="checkbox"/> Photo Passport No: _____ Country of Issue: _____ Or <input type="checkbox"/> Other (please specify) _____					
in my opinion, based on the above test results, is <u>NOT</u> capable of transmitting any of the above mentioned viruses.					
Comments (if applicable):					
Medical Practitioner's Signature:				Date:	
Medical Practitioner's Stamp (if applicable):					