



MEDICAL CLEARANCE FORM

ATHLETE INFORMATION

LAST NAME

FIRST NAME

MI

____/____/____
DATE OF BIRTH

MEDICAL CLEARANCE TO BE SIGNED BY PHYSICIAN

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

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