**WT MEDICAL REPORT**

* **This is a document for any athletes who wish to obtain a medical report of their injury or illness written by a medical official for their record**
* **This form can be filled out and issued only by WT Commissioned Doctor, Official Medical Director (OMD) or Consultant (Specialist) at OC designated hospital**

|  |  |
| --- | --- |
| **NAME OF THE COMPETITION (City/Country)** |  |
| **DATE OF REPORTING (DD/MM/YY)** |  |
| **NAME OF NATIONAL ASSOCIATION** |  |
| **ATHELTE NAME** **(first name / LAST NAME)** |  |
| **GENDER** | [ ] MALE [ ] FEMALE  |
| **WT GAL Number** |  |
| **Date of Birth** | (Day/ Month/ Year) |
| **Weight Division**  |  KG |
| **Date /Place of the Injury/Illness** |  |
| **Explanation of the Injury/Illness**(how the injury happened and what was the consequence of the injury) |  |
| **Diagnosis of the injury/Illness** |  |
| **Significant symptoms and findings****Imaging study result (x-ray, ultrasound, CT, MRI, etc)** |  |
| **The management of the injury****(treatment for the injured athletes)** |  |
| **Recommendations** |  |
| **Medical Examiner****(Name / Title/ Signature/ Email address)** |  |
| **Injured Athlete****(Name / Signature / Email address)** |  |
| **Team Official (head of team / coach / team medical staff) or Guardian****(Name / Signature /Email)** |  |