Serological Clearance Certification

This certificate must be completed by a Registered Medical Practitioner

I, _____
(Insert name of Medical Practitioner)

Being a registered Medical Practitioner,

Medical Practitioner Number: _____
(Insert number/stamp)

of: _____
(Insert address)

Declare that: _____
(Name of boxer)

Whom I identified from:

- ☐ Photo Driver's License No: _____
- or
- ☐ Photo in Medical Record Book of Combatant No: _____
- or
- ☐ Photo Passport No: _____ Country of issue: _____
- ☐ Other (please specify) _____

and based on the result of blood tests or other tests carries out on_____
(Insert date)

Is in my opinion NOT capable of transmitting a medical condition or disease.

Signature: _____
(Signature of Medical Practitioner)

Date: _____