# Physician Approval

**Athlete Name_____**

**DOB_____Age_____**

## Statement by Physician or Approved HealthCare Provider (MD, DO, NP & PA) for participation in Unified Lacrosse Inc. Programs and Activities

I hereby certify that I have examined the above mentioned athlete and find him/her physically fit to engage in Unified Lacrosse Inc. programs and activities.

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**Signature of Physician/Approved Provider**

**_____** **_____**

**Credentials** **Date**