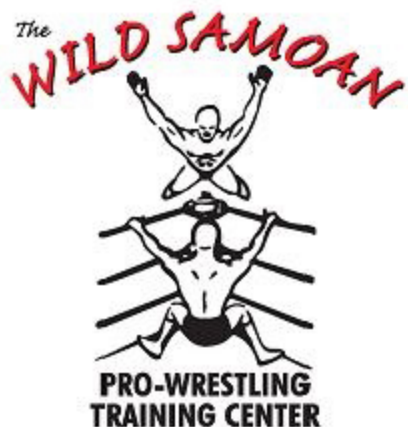


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PHYSICIAN'S CERTIFICATION

(No admittance granted without this completed certification)

The undersigned _____ hereby certifies as follows:
(Doctor's name)

1. I am a physician duly authorized to practice medicine in the state of _____.
2. I have conducted a complete physical examination of _____

(Students Name)

And certify that he / she is in excellent physical condition and able to participate fully with no limitations in the program offered by The Wild Samoan Training Center, Inc.

3. I understand that The Wild Samoan Training Center, Inc. will not allow _____ to enroll into the program with out this completed certification.

PHYSICIAN'S PRINTED NAME

PHYSICIAN'S SIGNATURE

DATE

RESULTS OF PHYSICAL MUST BE ATTACHED TO THE FORM.