MEDICAL CERTIFICATE CYCLOSPORTIVE

2024

LAST NAME: .....

FIRST NAME: .....

GENDER: MALE / FEMALE (delete as appropriate)

DATE OF BIRTH: .....

COUNTRY: .....

I undersigned, Doctor .....

certify that I have examined Mr/Mrs .....

and find him/her able to participate in competitive cycling events.

DATE OF THE MEDICAL EXAMINATION (COMPULSORY) : .....

Doctor's stamp (number of Medical Board's identification and address) compulsory	*Doctor's signature compulsory*