

MEDICAL CERTIFICATE CYCLOSPORTIVE

2023

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