

MEDICAL CERTIFICATE CYCLOSPORTIVE

2027

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