

# MEDICAL CERTIFICATE CYCLOSPORTIVE

2019

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*