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*