

COMPETITIVE MEDICAL CERTIFICATE

DOCTOR (name, last name) _____

BORN IN (city, nation) _____

ON (day/month/year) _____ | _____ | _____

DOCTOR OFFICE ADDRESS _____

PHONE / FAX NUMBER _____

Based on a physical examination done on (day/month/year) _____ | _____ | _____ which included a full medical sport check-up, a cardiac stress test with electrocardiogram, and a spirometry test, I hereby declare that

MR / MRS / MS (name, last name) _____

BORN IN (city, nation) _____

ON (day/month/year) _____ | _____ | _____

RESIDENTIAL ADDRESS _____

is in good health and fit to compete in a cycling competition in accordance with Italian law (D.M. 18/02/82 and D.M. 24/04/2013). This Sport Medical Certificate is considered valid to practice sport at agonistic

This certificate is valid for a period of one year.

CITY, NATION _____

DATE (day/month/year) _____ | _____ | _____

DOCTOR (signature and stamp) _____