

MÉDICAL CERTIFICATE CYCLOSPORTIVES

Name :

Given name :

Sex : Male Female

Date of birth : / /

Address :

Zip code : | _____ |

City:

Country:

Thank you return this certificate signed and dated by your doctor :

I, the undersigned Doctor :

Certify that I have examined Mr, Mrs, Miss:

And not having found that clinical signs of day-indicating apparent against the practice and training of cycling competition.

done at....., the/...../.....

<p>stamp and signature of the doctor.</p>
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