MÉDICAL CERTIFICATE
CYCLOSPORTIVES

Name : .....

Given name :.....

Sex : ☐ Male ☐ Female

Date of birth :..... /..... / .....

Address : .....

Zip code : I_____I

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 ...../...../.....

stamp and signature of the doctor.