MEDICAL FORM
CYCLOSPORTIVES

n° Ident GT:

Name : _____ First Name : _____
Sex (M/F) : _____ Date of birth : _____ / _____ / _____
Address : _____
Zip Code : _____ City : _____
Country : _____ Tel : _____ e-mail : _____

Please send the following certificate stamped and signed by your doctor :

I undersigned doctor : _____

Certify having examined Mr., Mrs., Miss :

_____

And find him capable of participating in competitive

Date, stamp and signature are obligatory.
