

Medical certificate to be issued on official  
doctor or medical centre letterhead

Place: \_\_\_\_\_ Date \_\_\_\_\_

## MEDICAL FORM

I undersigned doctor certify having examined

Name: \_\_\_\_\_

First name: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Country: \_\_\_\_\_

and find him/her capable of participating in long distance cycling races.

Dr. \_\_\_\_\_

Signature: \_\_\_\_\_