SPORT 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 track and field competition.

This Sport Medical Certificate is considered valid to practice sport at agonistic level.

This certificate is valid for a period of one year.

CITY, NATION ____

DATE (day/ month/ year) _______ | ________ | ________

DOCTOR (signature and stamp)