

# MEDICAL CERTIFICATE COMPETITIVE SPORT ACTIVITY

PLEASE, USE BLOCK LETTERS ONLY

The undersigned \_\_\_\_\_ (licensed physician)

on the basis of the medical test done on \_\_\_\_\_ (dd/mm/yyyy)

Diagnostic test as by the Italian law to be able to practice competitive sports activities  
(Ministerial Decree 18/02/1982)

## **Certify that**

Name \_\_\_\_\_ Surname \_\_\_\_\_

Born \_\_\_\_\_ in \_\_\_\_\_

Resident in \_\_\_\_\_ in \_\_\_\_\_

## **Can practice competitive Athletics sport activity**

This certificate will expire on \_\_\_\_\_

Date \_\_\_\_\_

The Doctor (stamp and signature) \_\_\_\_\_