



MEDICAL CERTIFICATE

Request in accordance with Italian legislation regulating participation at agonistic sports (DM 18/02/1982)

(ATTENTION! Only this form will be accepted! Medical Certificate will be valid for one year from date of issue)

Please fill in all spaces with **CAPITAL LETTERS** and return by e-mail to:

MEHT@sdam.it

Doctor (name, surname): _____

Office at (complete address): _____

Phone number: _____

I hereby declare that, Mr/Mrs/Ms (name, surname): _____

Born (city, country): _____

On (dd/mm/yyyy): _____/_____/_____

Resident (city, address, country): _____

Does not reveal any contraindication to practice competitive athletic sport activities (running, trail).

Place: _____ Date: _____/_____/_____

Doctor signature/stamp: _____

(Please indicate doctor professional register number)