



La Clusaz
Haute Savoie - France



MEDICAL CERTIFICATE 2018

I, the undersigned, Dr, Doctor of Medicine,
 certify that the examination of Mr/Mrs,
 Date of birth ____ / ____ / ____ Age :
 reveals no contraindications to participating in an MOUNTAIN BIKE competition.

Medical certificate issued in (place) :

Date :

Doctor sign :

Doctor stamp :
 (practice name, adress, phone number, doctor's name) :