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:
UTLM@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)