MEDICAL FORM
CYCLOSPORTIVES

Name :……. First Name :……..

Sex (M/F) : ……

Date of birth : …../ ….. /……

Address :…….

Zip Code :……. City :……..

Country :……. Tel. :……...

e-mail : ……

Please stamped and signed the following certificate by your doctor :

I undersigned doctor :……..

Certify having examined Mr., Mrs., Miss

:…….

And find him capable of participating in competitive Tour of Crete

Date, stamp and signature are obligatory