SPORT MEDICAL CERTIFICATE

DOCTOR (name, last name): …….

BORN IN (City, Nation): …….

ON (day/month/year): …….

DOCTOR OFFICE ADDRESS: …….

…….

…….

PHONE NR. …….

Based on a physical examination done on (day/month/year) ……./……/…… nearby declare that:

MR/MRS/MS (name, last name) …….

BORN IN (City, Nation): …….

ON (day/month/year): …….

RESIDENTIAL ADDRESS …….

…….

there is no clinical evidence or congenital disease that prevents the patients from practicing not competitive sport activity.
(Validity one year)

CITY: …….

DATE (day/month/year) …….

DOCTOR

Place/date Signature

…….. ……