# HEALH FORM

FAX 0039 075 630 623 90 - maratonadisanvalentino@dreamrunners.it

DR SURNAME

DR NAME

BORN(CITY, COUNTRY)

ON (DD/MM/YYYY)

WITH OFFICES ADDRESS AT (COMPLETE ADDRESS)

AND PHONE NUMBER

HEREBY STATE

that Mr / Mrs / Ms (name, surname)

born (city, country)

on (dd / mm / yyyy)

and resident at (address, city, country)

ID document N°

according to the results of medical check-ups and examinations, is healthy and currently fit for competitive sports in general and for the marathon in particular.
this certificate is valid until (dd / mm / yyyy)

*The certificate must be valid at least until 31/03/2012 included.*

date (dd / mm / yyyy)

Physician's signature and stamp