

# Medical Certificate

I, the undersigned Dr \_\_\_\_\_, Doctor of Medicine Certify that  
the examination of **Mr./ Ms./ Mrs.** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_  
\_\_\_\_\_ **Age** \_\_\_\_\_ reveals no contraindications for participating in a \_\_\_\_\_  
\_\_\_\_\_ .

Medical certificate issued in \_\_\_\_\_

Date \_\_\_\_\_

Doctors Signature \_\_\_\_\_

Doctor Stamp \_\_\_\_\_