



Le Bélier
VTT



La Clusaz
Haute Savoie - France

MEDICAL CERTIFICATE 2025

I, the undersigned, Dr, Doctor of Medicine,
certify that the examination of Mr/Mrs,
Date of birth ____ / ____ / ____ Age :
reveals no contraindications to participating in an MOUNTAIN BIKE competition.

Medical certificate issued in (place) :

Date :

Doctor sign :

Doctor stamp :
(practice name, adress, phone number, doctor's name) :