

HEALTH DECLARATION

WE PLEASE YOU TO FILL WITH CAPITAL LETTERS
SEND THIS FORM BY FAX OR E-MAIL **+39 0519525760 / runtuneup@sdam.it**

PHYSICIAN *first and last name* _____
birth place *city, ZIP, country* _____
date of birth *dd/mm/yyyy* _____
ambulatory *city, ZIP, country* _____
phone number _____
e-mail _____

PATIENT *first and last name* _____
birth place *city, ZIP, country* _____
date of birth *dd/mm/yyyy* _____
residence *city, ZIP, country* _____
phone number _____
e-mail _____
disability *if applicable* _____

The physician declare that the patient is in good health and fit to compete in a 21,00 km half marathon, according to the sport physical exam done by himself on (dd/mm/yyyy) _____.

The physician is fully responsible for consequences of falsely declaring. This certificate is valid one year from this date.

PRIVACY AND SIGNATURE

By completing and signing this registration form to UniSalute RUN TUNE UP 2018, I declare that I have read and specifically approves, in its entirety, the rules of the event.

DATE dd/mm/yyyy ____/____/____

PHYSICIAN SIGNATURE _____