HEALTH DECLARATION

WE PLEASE YOU TO FILL WITH CAPITAL LETTERS

SEND THIS FORM BY FAX OR E-MAIL **fax +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 2020, I declare that I have read and specifically approves, in its entirety, the rules of the event.

DATE dd/mm/yyyy _____/_____/_____ PHYSICIAN SIGNATURE _____

ASSOCIAZIONE **RUN TUNE UP**
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