**MEDICAL CERTIFICATE**

(To be handed over at the time of distribution of bib numbers)

(To be filled in by a Doctor)

I, the undersigned Dr\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Doctor of Medicine,

today, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby certify that I have today examined of

Mr/Ms \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

and have not found any obvious reason why they should not take part in a competitive triathlon event for a sprint (swim 0.75, bike 20, run 5), Olympic (1.5, 40, 10) or long distance (over 2km, 90km, 21km) (underline whatever applicable).

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| --- | --- |
| Doctors sign: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Medical certificate issued in (place): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Doctor Stamp: | Medical institution stamp: |