

# Ultra-Trail® Via degli Dei



## HEALTH FORM

This form has to be filled in, dated and signed by the doctor  
PLEASE USE BLOCK LETTERS

I, Dr. (name, surname) \_\_\_\_\_  
born (city, country) \_\_\_\_\_ on (dd/mm/yyyy) \_\_\_\_\_  
with office at (complete address) \_\_\_\_\_

Phone number \_\_\_\_\_ declare myself fully responsible and  
acknowledge the consequences for falsely declaring that  
Mr./Mrs. (name/surname) \_\_\_\_\_  
born (city, country) \_\_\_\_\_ on (dd/mm/yyyy) \_\_\_\_\_  
and resident at (complete address) \_\_\_\_\_

with the following disability (if applicable) \_\_\_\_\_

based on a sport physical exam done by me on (dd/mm/yyyy) \_\_\_\_\_  
does not reveal any indication against the practice of running in competition  
according to current laws.

This certificate is valid one year from this date.

Date: \_\_\_\_\_ Doctor's signature and stamp: \_\_\_\_\_