

## Certificate To Practice Agonistic Sporting Activities

Doctor's official stamp

Surname \_\_\_\_\_

Name \_\_\_\_\_

Date of birth \_\_\_\_\_

Residential Address

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

This certificate confirms that \_\_\_\_\_ has been physically examined and completed ECG tests, (pre and post exercise), and is clinically fit and healthy to participate in agonistic sporting events.

Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_

### Declaration

I the undersigned declare that I have informed the doctor of my current mental and physical condition.

Date \_\_\_\_\_

Patient's Signature \_\_\_\_\_