Medical Certificate

Please complete the following:

Name:_____

Surname: _____

Address:

_____

_____

Tel: _____

Emergency Contact Name_____

Emergency contact No_____

To be filled in by your GP/Doctor/Medical Practitioner

I, _____ , the undersigned, see no reason that the above participant, or examination, cannot take part in the Headway cycle challenge.

Doctor's Stamp

Doctor's Signature _____

Date: _____