

If yes, please provide detailed information on a separate page (*typed or computer-generated with the applicant's full legal name and date of birth at the top of each page*).

### CERTIFICATION

I certify that I hold a valid current license to practice medicine and am not an immediate relative of the patient, and that I have personally examined the applicant, \_\_\_\_\_, and reported my findings as noted above and the attached page(s) (if no pages are attached, please check here: ).

I find the applicant:

- In good health and not suffering from any mental or medical condition(s) that would preclude participation in the program  
 Suffering from mental or medical condition(s) as noted in my report

I find the applicant in good health and not suffering from any condition(s) that would preclude participation in sporting/physical activities of the applicant's choice.  Yes  No

Physician's Name (type or print)	Signature (in blue ink)	Date (e.g., 01/Jan/2006)
<i>Costa e Silva (nome do médico)</i>		<i>03/Apr/2008</i>

Physician's address, phone, and fax (type or stamp)

*Address – Street : Rua xxxxxxxxxxx, 1.049 – sala 905 - Bairro xxxxxxxxxxx*

*City: Belo Horizonte*

*State: Minas Gerais*

*Postal Code: 30.999-999*

*Country: Brazil*

*Phone: +55 31 9999 9999*