All information contained in this form is treated in a confidential manner.

Please complete the form in a legible way (in block letters). Thanks.

Name:       Surname:

Birth date:       Address:

Postcode:       City:

A) Do you suffer from an allergy? Yes [ ]  No [ ]

If yes, specify which one and indicate the medical treatment prescribed:

B) Do you follow a diet? Yes [ ]  No [ ]

 If yes, specify:

C) Are you currently suffering from health problems or from consequences of an accident? Yes [ ]  No [ ]

 If yes, specify:

D) Are you on a medical treatment? Yes [ ]  No [ ]

 If yes, specify:

If yes, please, provide to the Service a medical certificate that testifies what you

have just declared.

E) Are you on a psychological/psychiatric treatment? Yes [ ]  No [ ]

 If yes, specify:

If yes, please, provide to the Service a certificate that testifies what you have just declared.

F) Do you plan to undergo an operation
or to be hospitalized? Yes [ ]  No [ ]

G) Do you suffer from alcoholism
or other addictions (drugs, medicaments)? Yes [ ]  No [ ]

H) Do you smoke? Yes [ ]  No [ ]

I) Other health issues, if necessary:

A false declaration stated at the points A) – H) can justify the Service Mobilità e scambi to cancel of your enrolment to the program.

IN FAITH:

Date: Signature: