



Spokesperson of the team
competitivi@podisticaospedaliieripisa.it

Groups co-ordinator (Deputy President)
vice-presidente@podisticaospedaliieripisa.it

Members office
segreteria.soci@podisticaospedaliieripisa.it

OSPEDALIERI'S COMPETITIVE TEAM MEMBERSHIP FORM

(fill out every field in block letters)

I, the undersigned, hereby

Name

Last name

Birth date(dd/mm/yyyy)

Full birth place

Full home address and street number

Full residence address and street number (fill out only if different from home address)

Phone number

Cell. number

FIDAL (IAAF) card number

e-mail address

Social security number/Codice Fiscale

enrolled in A.S.D. Podistica Ospedaliieri for the year _____
year (yyyy)

request

to be included in the competitive team for the duration of the season currently in progress. To this end I declare:

- to be aware and to accept the rules provided for the activities of this group;
- to have received the information in art. 13 of the Italian Legislative Decree 196/2003, in particular the rights recognized to me in art. 7 of that Decree;
- to authorize the use of my personal details solely for circulation within the association in relation to the Italian Legislative Decree n° 196/2003.

Place and date

signature of applicant (full and clear)