INSTRUCTION

Medical **D**iagnostic **F**orm
For athletes with Physical impairments

WORLD PARA TAEKWONDO

EN

- This form must be completed in **ENGLISH** by the Member National Association (MNA)'s physician or team doctor.

- Must be submitted by **REGISTRATION DEADLINE** of the event through World Taekwondo Classification System (WTCS) *https://db.ipc-services.org/wtcs/app/login*

- Any supporting documents *(e.g. photo or medical report)* must be submitted also to WTCS, and all documents **PRINTED** and **BROUGHT** with the athlete during the athlete evaluation session.

- **PHOTO** of the athlete is **MANDATORY.**
- **See PHOTO GUIDE next page.**
- Must be submitted also to WTCS under supporting documents.

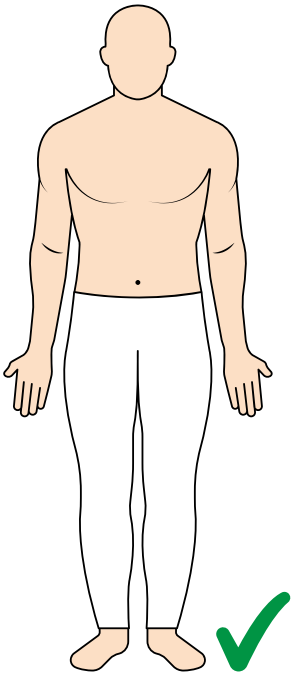
- The Assessment group may ask for further documents to be submitted depending on the individual athlete's health condition and impairment.

- For further information, please contact Para Taekwondo Department at *classification@worldtaekwondo.org*

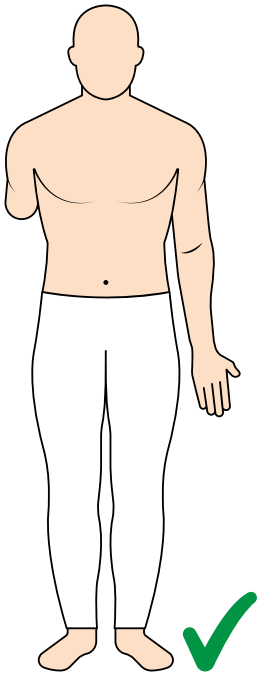
PHOTO GUIDE

Medical **D**iagnostic **F**orm
For athletes with Physical impairments

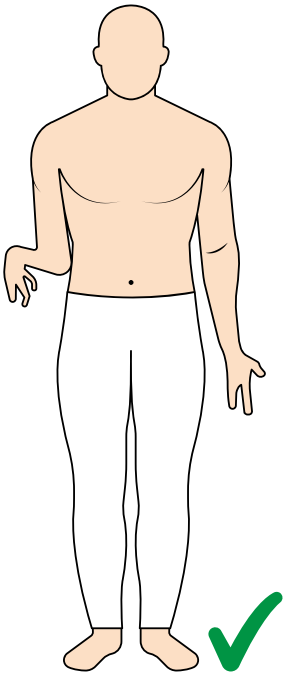
WORLD PARA TAEKWONDO



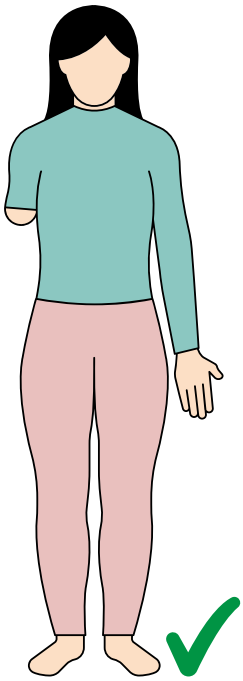
Anatomical position & white background



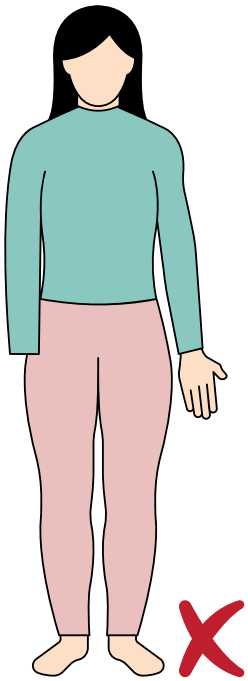
Amputation or Dysmelia



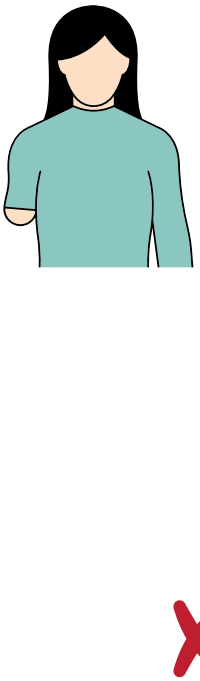
Arm contracture stretched as possible



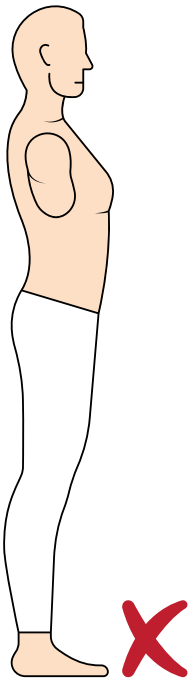
If wearing T-shirt, affected arm(s) showing



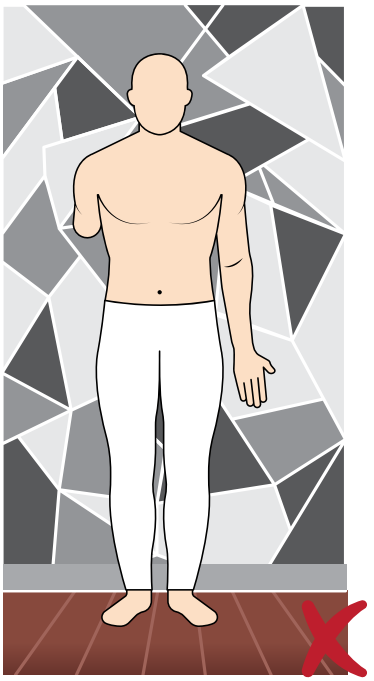
Affected arm(s) not showing



Part body photo



Sideway photo



Background

MDF

Medical **D**iagnostic **F**orm
For athletes with Physical impairments

WORLD PARA TAEKWONDO

Athlete Information

First Name:		Last Name:	
Date of Birth *dd/mmm/yyyy:*		Gender:	-
Discipline:	-	How long competing:	
Member National Association:		WT License:	

Eligible Impairment type(s):

☐ Limb deficiency ☐ Impaired muscle power ☐ Impaired passive range of movement

☐ Leg length difference ☐ Short Stature

Underlying Health Condition:

☐ Amputation ☐ Dysmelia/ malformation ☐ Brachial plexus ☐ Brain or Spinal cord injury

☐ Joint contracture ☐ Peripheral Nerve injury ☐ Poliomyelitis ☐ Dwarfism

Others, please specify:

Details of the impairment *(Please give details of the history how the impairment happened):*

Health condition is:	-	-	If acquired, age of onset:
Using any adaptive devices	-	If yes, please describe:	
Anticipated future procedure(s):	-		
Medication (s):	-		

Declaration signed by MNA physician or Team doctor:

☐ **I confirm that the above information is accurate.**

Name:			
Health care profession:			
Professional registration number:			
Address:			
City:		Country:	
Phone:		E-mail:	
Date *dd/mmm/yyyy*:		Signature:	

CHECKLIST
Tick all applicable options

☐ Photo ☐ Medical report ☐ Electromyograph "EMG" ☐ Nerve conduction test

☐ Others, please specify: