Para-Archery Classification

Medical Information Intake Form

WORLD ARCHERY FEDERATION
FÉDÉRATION MONDIALE DE TIR À L'ARC
Maison du Sport International
Avenue de Rhodanie 54
1007 Lausanne, Switzerland
Phone: +41 (0)21 614 30 50
Fax: +41 (0)21 614 30 55
E-mail: info@archery.org
www.archery.org

This form must be completed in the *English language* prior to classification. Following completion a physician familiar with the applicant's medical condition, disease, or injury must sign the completed document and provide national medical society or board of practice information for verification purposes.

As this form represents the first step in the classification process, the information provided must be honest, accurate, and verifiable. Successful completion of this form does not indicate that a classification will be performed. Rather, it provides a concise basis of discussion between the applicant and classification team regarding the applicant's potential for being successfully classified as a para-archery competitor.

The completed form must be submitted less than one year prior to classification scheduling.

The information provided on this form is essential to verify that the medical condition, disease, or injury that the applicant has sustained has a clear impact on their ability to function in the sport of archery.

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Applicant Information

Surname First name	
Date & Place of Birth (DD/MM/YYYY)	
National Governing Body (Member Association)	
Primary Diagnosis (the major medical condition, disease, or injury that impacts the applicant's ability to perform the sport of archery	
Date of diagnosis (DD/MM/YYYY)	
Significant functional limitations and/or impairments associated with the Primary Diagnosis	
Summary of Special Tests that confirm the Primary	

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Diagnosis (may include information provided by X-rays, Magnetic Resonance Images, Diagnostic Electromyography, or other tests deemed appropriate by a treating physician)	
Secondary Diagnosis (a secondary medical condition, disease, or injury that when combined with the primary medical diagnosis impacts the applicant's ability to perform the sport of archery)	
Date of diagnosis (DD/MM/YYYY)	
Significant functional limitations and/or impairments associated with the Secondary Diagnosis	
Summary of Special Tests that confirm the Secondary	

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Diagnosis (may include information provided by X-rays, Magnetic Resonance Images, Diagnostic Electromyography, or other tests deemed appropriate by a treating physician)	
Any other medical conditions, diseases, injuries, or extenuating circumstances that may impact the applicant's ability to perform the sport of archery	

By signing this document we confirm that the information provided is honest, accurate, and verifiable.

Applicant signature

Date and Place

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Physician Information

Surname First name	
Signature	
Physician National Medical Society or National Board of Practice	
Physician Registration Number/ Not applicable	