# INSTRUCTION

**M**edical **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.**
- Check 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

**M**edical **D**iagnostic **F**orm
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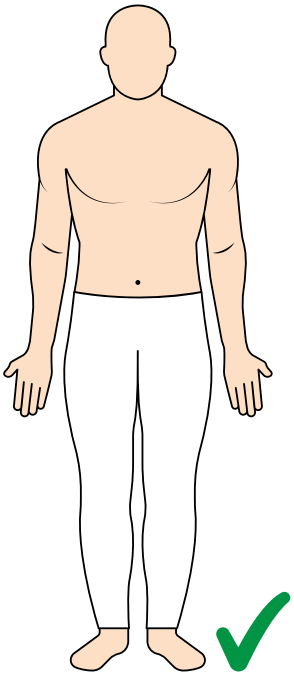
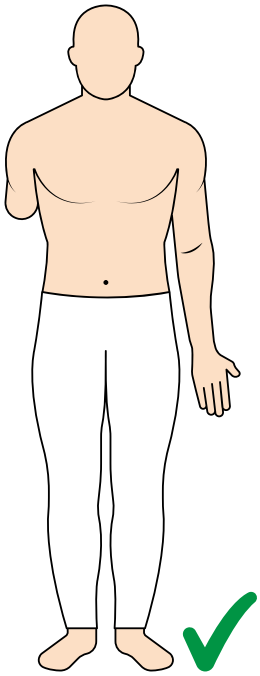
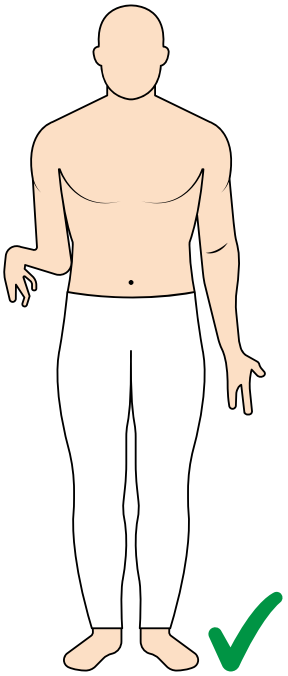
WORLD PARA TAEKWONDO



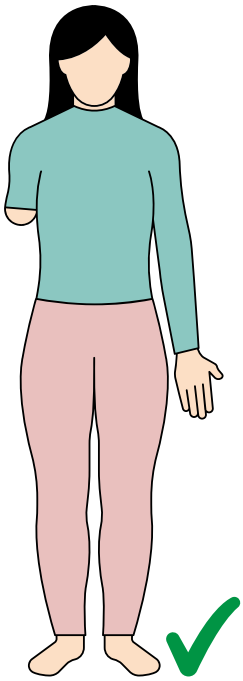
Anatomical position & white background



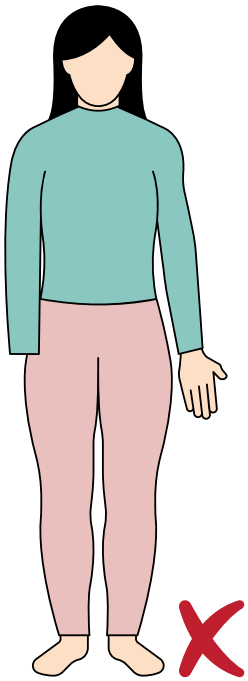
Amputation or Dysmelia



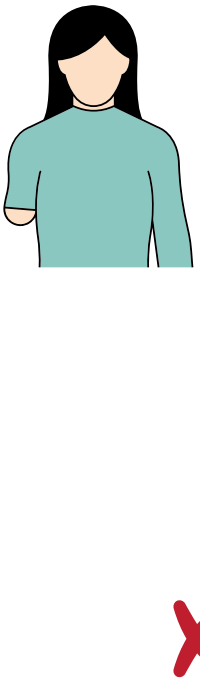
Arm contracture stretched as possible



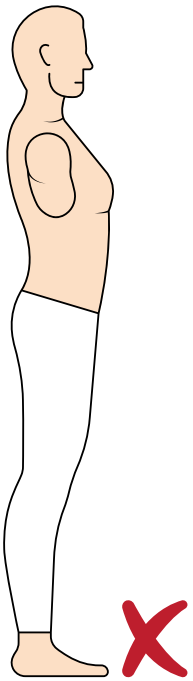
If wearing T-shirt, affected arm(s) showing



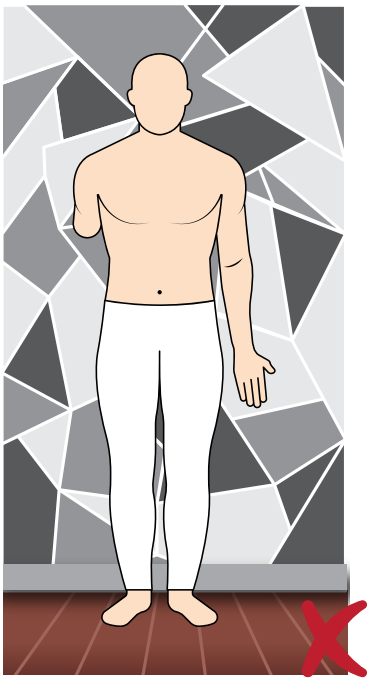
Affected arm(s) not showing



Part body photo



Sideway photo



Background

MDF

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

☐ Others, please specify: