



ITF MEDICAL REGISTRATION FORM

TO BE COMPLETED IN THE ENGLISH LANGUAGE

PLEASE PRINT IN BLACK INK ENSURING ALL INFORMATION IS CLEAR

PART 1: PLAYER INFORMATION *(Part 1 to be completed by the player)*

FAMILY NAME(S): _____ FIRST NAME(S): _____

FEMALE MALE *(select appropriate box)* Date of Birth (dd/mm/yr): _____

Home address: _____

Street Address

City

State / County

Country

Zip / Postal Code

Telephone: _____ Mobile: _____ Fax: _____

Email address: _____ (please print CLEARLY)

Nature of Disability: (e.g. spinal cord injury, muscular dystrophy, post-polio syndrome, spina bifida, amputation, dysmelia, etc)

Date of Onset of Disability (dd/mm/yr): _____

Name of National Association: _____

Country of Citizenship: _____ Nationality: _____

Have you previously applied for status in wheelchair tennis? Yes/ No

CONDITIONS OF PARTICIPATION

- (i) I, the undersigned Player, confirm that I have read and have understood the provisions contained in the Wheelchair Tennis Rules and Regulations ("Rules and Regulations") (a copy of which is also on the website) and the Wheelchair Tennis Classification Rules ("Classification Rules"). I hereby agree to abide by the Rules and Regulations, the Wheelchair Tennis Classification Rules and Rules of Tennis and any modifications thereof, including the Code of Conduct.
- (ii) I hereby further agree to be bound by any and all decisions made by the ITF Wheelchair Tennis Committee and/or the ITF under the Rules and Regulations, the Wheelchair Tennis Classification Rules, Rules of Tennis and/or Code of Conduct. I further accept that I may be subject to penalties (financial or otherwise) if I fail to comply with the provisions of the Rules and Regulations, the Wheelchair Tennis Classification Rules, Rules of Tennis and/or Code of Conduct. I agree to discharge any such financial penalties, which may be imposed on me by the ITF Wheelchair Tennis Committee.
- (iii) I hereby acknowledge that Wheelchair Tennis is a physically demanding sport and that it is my responsibility to ensure that I am physically and medically fit to participate in any ITF sanctioned Wheelchair Tennis event.
- (iv) I further acknowledge that participation in Wheelchair Tennis carries with it inherent risks of injury and/or other damage or loss to person and/or property. I acknowledge that my participation in any ITF sanctioned Wheelchair Tennis event is on a voluntary and informed basis with respect to such risks and therefore that I am personally assuming such risks. It is my responsibility to insure against such risks should I choose to do so and not the responsibility of the ITF and/or ITF Wheelchair Tennis Committee. In any event, I shall have no recourse against the ITF and/or the ITF Wheelchair Tennis Committee in the event that I do suffer such injury and/or other damage or loss to person or property.
- (v) I understand and accept that when entering into any ITF sanctioned Wheelchair Tennis event, including the Wheelchair Tennis Tour, the World Team Cup and Paralympic Games, neither the ITF Wheelchair Tennis Committee, the ITF nor any of their respective officers, agents or employees shall be liable to me in respect of my death, personal injury, loss of, or damage to property that I may sustain, however caused, while travelling to and from and/or participating in any ITF sanctioned Wheelchair Tennis event, save where such

injury and/or loss was incurred as a direct result of negligent acts or omissions on the part of the ITF and/or ITF Wheelchair Tennis Committee or any of their respective officers, agents or employees.

- (vi) I further understand and accept that my participation in any ITF sanctioned wheelchair tennis event shall also represent definitive proof of my acknowledgement and acceptance of other relevant consents and agreements herein.

ELIGIBILITY

I acknowledge and accept that compliance with the eligibility rules is fundamental to maintaining the integrity of wheelchair tennis and that it is necessary and reasonable for the ITF to verify my eligibility to participate and for the ITF and other relevant committees/personnel to have access to my medical details for such purposes.

- (i) I agree to inform the ITF if my level of functional disability materially improves
- (ii) I agree that if the ITF, Classifiers and or any such persons instructed by the ITF require additional evidence and/or information and/or assistance for the purposes of assessing my eligibility (including the provisional medical evidence or otherwise), that I shall provide and/or facilitate the provision of such evidence, information and/or assistance at my expense and within the time limit directed by the ITF and/or classifier as the case may be. I further acknowledge and accept that a failure to provide such information, evidence and/or assistance within the time limit, may delay the determination of my eligibility and that during such period I shall not be eligible to play.
- (iii) I agree and consent to my doctor and/or relevant persons and/or entities disclosing medical information and documentation to the ITF and its relevant Committees and/or relevant persons for the purposes of assessing and/or reviewing my eligibility to play and other relevant matters and that I agree that this information and that set out above may be used for these purposes. I knowingly waive any applicable duties of confidentiality in this regard.

ITF TENNIS ANTI-DOPING PROGRAMME PLAYER CONSENT AND AGREEMENT

I, the undersigned Player acknowledge that I have received and have had an opportunity to read the ITF Tennis Anti-Doping Programme (the "Programme"). I confirm that I understand the provisions of the Programme including what constitutes a Doping Offence thereunder, and I hereby consent and agree:-

I am bound by and will comply with the Tennis Anti-Doping Programme (the "Anti-Doping Programme"), a copy of which is available upon request from the ITF or may be downloaded at <http://www.itftennis.com/anti-doping>. The Anti-Doping Programme will govern my participation in ITF-sanctioned events (together with the ITF Rules, including the Player Code of Conduct and the Tennis Anti-Corruption Program, each of them applying concurrently and without prejudice to the other). The ITF may conduct anti-doping testing at ITF-sanctioned events under the Anti-Doping Programme, and will enforce any penalties, sanctions and/or other measures taken against me under the Anti-Doping Programme. I hereby submit to the jurisdiction and authority of the ITF to manage, administer and enforce the Anti-Doping Programme and to the jurisdiction and authority of the Anti-Doping Tribunal and the Court of Arbitration for Sport ("CAS") to determine any charges brought under the Anti-Doping Programme.

I hereby confirm that I have read, understood and agree to be bound by the terms of this Player Consent Agreement.

PLAYER AGREEMENT AND ACCEPTANCE OF PART 1:

_____ (Print Name Player) DATE (mm/dd/yr): _____

_____ (Sign Name Player)

PLEASE NOTE THAT THIS SECTION MUST BE COMPLETED BY THE MEMBER NATION BEFORE SUBMITTING TO THE ITF

PLEASE PRINT CLEARLY IN BLACK INK

NAME OF PLAYER

PART 2: NATIONAL ASSOCIATION [MUST BE AFFILIATED MEMBER NATION TO THE ITF]

National Association: _____

Contact Name: _____

Address: _____

Street Address

City

State / County

Country

Zip / Postal Code

Telephone: _____ Mobile: _____ Fax: _____

Email address: _____ (please print CLEARLY)

I hereby declare that:

- (i) To my knowledge the information stated in part 1 is correct
- (ii) Doctor _____ is a registered doctor in our country

NATIONAL ASSOCIATION AGREED AND ACCEPTED PART 3:

_____ (Print Name) DATE: _____

_____ (Sign Name)

Please send the completed and signed registration form and any supporting doctor's forms to:

By email:

wchclassification@itftennis.com

By post:

**ITF Ltd
Wheelchair Tennis Department
Bank Lane
Roehampton
London SW15 5XZ
Great Britain**

MEDICAL DIAGNOSTICS FORM FOR WHEELCHAIR TENNIS

This form must be completed in English by a registered medical doctor (MD) who has **specialization in the Player's health condition**.

The completed form **with attached medical documentation MUST be uploaded / sent with the ITF registration form**.

Depending on the Player's health condition and impairment, additional medical information must be attached to this form (see page 2; Eligibility (i), (ii), (iii)).

NOTE: The measurement of impairment seen during Player evaluation must correspond to the diagnosis indicated below. If the medical documentation is incomplete, the International Tennis Federation holds the right to request further information. In the absence of such information, the Player will not be able to proceed to the Player Evaluation.

PLAYER INFORMATION

Family Name:		
Given Name:		
Gender:	<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	Date of Birth: _____ (dd/mm/yyyy)

MEDICAL INFORMATION

Note: The list of medical diagnosis shows examples and is not exhaustive

Please note the digital documents used to support the diagnosis **MUST** be attached in **ENGLISH** for **ALL** players. File formats accepted include; PDF, JPEG, JPG, XLS DOC, Plain Text files (.txt) any file compatible with Mac and Windows.

Eligible Impairment (tick)	Name medical diagnosis relevant to impairment type (tick or add)	Digital documents to support the diagnosis (tick <u>AND</u> add to all that apply)
<input type="checkbox"/> Impaired muscle power	<input type="checkbox"/> Spinal Cord Injury <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Spina Bifida <input type="checkbox"/> Polio Myelitis <input type="checkbox"/> Multiple Sclerosis Other _____	<input type="checkbox"/> Medical Report <input type="checkbox"/> ASIA Scale <input type="checkbox"/> Electromyography <input type="checkbox"/> MRI (and Medical Report) <input type="checkbox"/> X-Rays (and Medical Report) <input type="checkbox"/> Muscle Power Tests (Scale 0-5) <input type="checkbox"/> Biopsy Other _____

<input type="checkbox"/> Impaired passive range of movement (pROM)	<input type="checkbox"/> Arthrogyposis <input type="checkbox"/> Joint contractures <input type="checkbox"/> Trauma Other _____	<input type="checkbox"/> Medical Report <input type="checkbox"/> X-rays (and Medical Report) <input type="checkbox"/> Photographs <input type="checkbox"/> Goniometric measures of joint limitations
<input type="checkbox"/> Leg length difference	<input type="checkbox"/> Trauma <input type="checkbox"/> Dysmelia Other _____	<input type="checkbox"/> Medical Report <input type="checkbox"/> X-rays (and Medical Report) <input type="checkbox"/> Photographs Other _____
<input type="checkbox"/> Limb deficiency	<input type="checkbox"/> Dysmelia <input type="checkbox"/> Traumatic amputation <input type="checkbox"/> Bone cancer Other _____	<input type="checkbox"/> Medical Report <input type="checkbox"/> X-rays (and Medical Report) <input type="checkbox"/> Photographs Other _____
<input type="checkbox"/> Ataxia <input type="checkbox"/> Athetosis <input type="checkbox"/> Hypertonia	<input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Traumatic Brain Injury <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Stroke Other _____	<input type="checkbox"/> Medical Report <input type="checkbox"/> Modified Ashworth Scale <input type="checkbox"/> Cerebral MRI or CT scan Other _____

Additional details on medical diagnosis (*This must include identifying which limbs are affected and further details on impairment – ie difference in leg length*):

MEDICAL HISTORY

To help assist with defining the difference between **Stable** and **Permanent**, a person with a spinal cord injury sustained 5 years ago would be generally considered to have a permanent, stable health condition. A person with a spinal cord injury sustained 6 months ago may not yet have a stable health condition in terms of their neurological recovery, depending on the completeness of injury.

Player's Condition is	<input type="checkbox"/> Stable	<input type="checkbox"/> Progressive	<input type="checkbox"/> Fluctuating	<input type="checkbox"/> Permanent
Date of Onset	(yyyy)		<input type="checkbox"/> Congenital	
Past Treatments				
Current Treatments				
Anticipated future treatments:				

Medications and reason for prescription:
--

<input type="checkbox"/> I confirm that the above information is accurate.	
Name:	
Medical Specialty:	
Registration Number:	
Address:	
City:	Country:
Phone:	E-mail:
Date:	Signature: