

REGISTRATION FORM FOR WHEELCHAIR BASKETBALL PLAYERS

This form must be completed in full by a Medical or paramedical person and/or International Classifier, person responsible for Classification and sent to IWBF.

PLAYER INFORMATION:

Last Name:			
First Name:			
Date of birth (DD/MM/YYYY):			
Nationality:			
Gender:	Male:		Female:

PERMANENT HEALTH CONDITION & RESULTING IMPAIRMENT:

Health Condition / Diagnosis

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Resulting impairment

Ataxia		Athetosis		Hypertonia	
Limb deficiency / loss		Leg length difference			
Impaired muscle power		Impaired passive range of movement			

Medical condition is

Permanent		Stable		Progressive	
Year of onset:				Congenital (birth):	

Chronology of Health Condition	
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I can confirm that the above information is accurate

Name:			
Date:		Signature	

