

REGISTRATION F	HFFI CHAIR I	RASKETRALI	ΡΙΔΥFRS
NEUISINATION F		DAJKLIDALI	

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	INFORM	ATION:						
Last Nam	ie:							
First Nan	ne:							
Date of b	oirth (DD/N	MM/YYYY):						
National	ity:							
Gender:			Male	9:		Fen	nale:	
PERMA	NENT HE	ALTH CONI	DITION	& RESULTING II	MPAIRI	MEN	T:	
			Health	Condition / Dia	gnosis			
Resulting impairment								
Ataxia				Athetosis			Hypertonia	
Limb def	iciency / lo	oss		Leg length differ	ence			
Impaired muscle power			Impaired passive range of movement					
Medical condition is								
Permane	nt			Stable			Progressive	
Year of o	nset:				Co	ongeni	ital (birth):	
Chronology of Health Condition								
I can confirm that the above information is accurate								
Name:				11				
Date:				Signature				

International Wheelchair Basketball Federation **IWBF** c/o FIBA Route Suisse 5 – P.o. Box 29 1295 Mies - Switzerland



TO BE FILLED IN BY CLASSIFIER						
Proposed	d Classification:		Proposed by:			
I can confirm that the information above is accurate						
Name:						
Date:			Signature			

RATIONALE FOR PROPOSED CLASSIFICATION:

I, as a participant in an International Wheelchair Basketball Federation authorized or recognized event, hereby acknowledge and agree to the following:

- 1. I consent to the use by IWBF of photographs and videos taken of me during IWBF competitions.
- 2. I certify that the information provided is correct.
- 3. If necessary, to complete my classification, I consent to a private physical assessment by members of the tournament classification panel

Signature (or, if a minor, signature of legal guardian)

Date

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