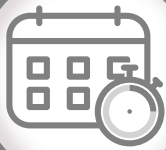


EN

- 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.



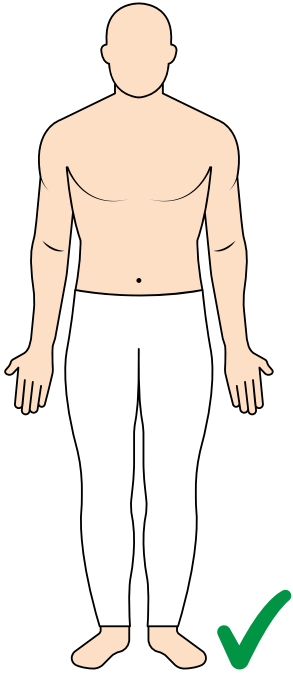
- The Assessment group may ask for further documents to be submitted depending on the individual athlete's health condition and impairment.



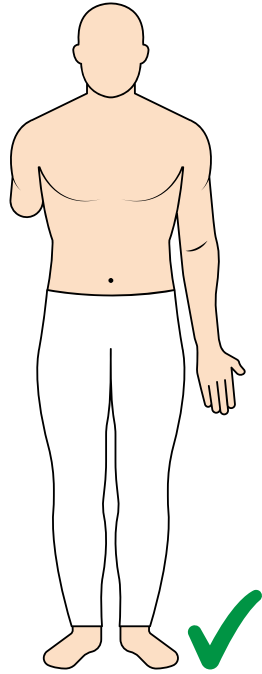
- For further information, please contact Para Taekwondo Department at [classification@worldtaekwondo.org](mailto:classification@worldtaekwondo.org)

# PHOTO GUIDE

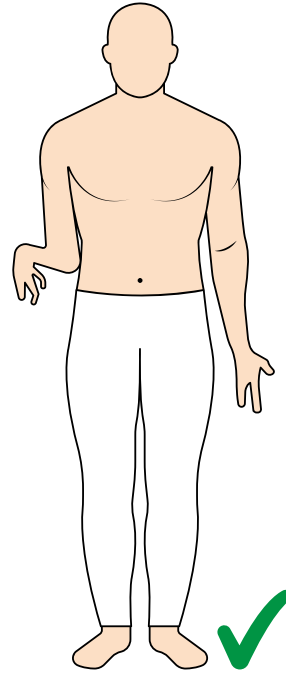
Medical Diagnostic Form  
For athletes with Physical impairments



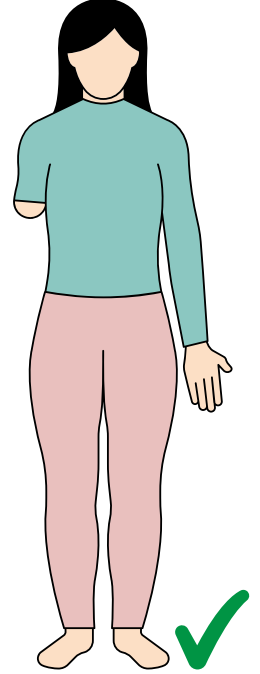
Anatomical position  
& white background



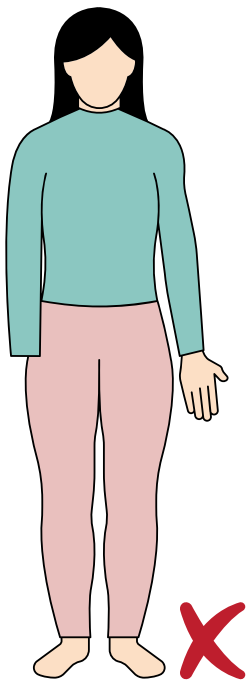
Amputation  
or Dysmelia



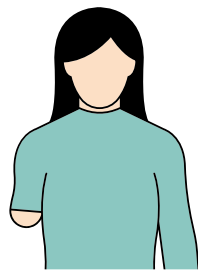
Arm contracture  
stretched as possible



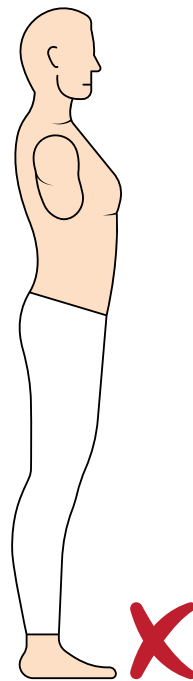
If wearing T-shirt,  
affected arm(s) showing



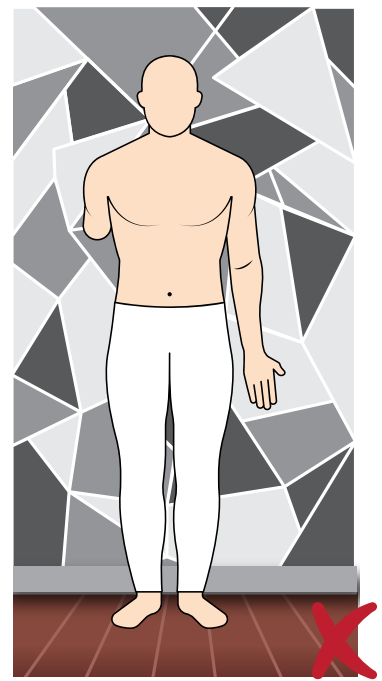
Affected arm(s)  
not showing



Part body photo



Sideway photo



Background

**Athlete Information**

First Name:	Last Name:
Date of Birth <i>dd/mmm/yyyy</i> :	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	

**Primary Medical Diagnosis:**

Amputation	Dysmelia/ malformation	Brachial plexus	Poliomyelitis
Joint contracture	Peripheral Nerve injury	Brain injury	Spinal cord injury
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:
Anticipated future procedure(s):
Medication (s):

**Declaration signed by MNA physician or Team doctor:**

<b>I confirm that the above information is accurate.</b>			
Name:			
Health care profession:			
Professional registration number:			
Address:			
City:		Country:	
Phone:		E-mail:	
Date <i>dd/mmm/yyyy</i> :		Signature:	

**CHECKLIST**

Photo

Medical report

Electromyograph "EMG"

Nerve conduction test

Others, please specify: