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| C:\Documents and Settings\selvam\Local Settings\Temp\Temporary Directory 1 for New BWF Logo.zip\BWF_logo_CMYK.jpg | **PARA BADMINTON**  **MEDICAL REVIEW REQUEST FORM** |
| ***Who******should******make******a******Medical******Review******Request?***  *A Medical Review Request needs to be submitted for Players with Sport Class status Confirmed, if their impairment and/or activity limitations are no longer consistent with their current Sport Class.*  *A Player’s impairment and/or activity limitations are no longer consistent with their current Sport Class if:*   * *A Player’s relevant impairment or activity limitation has become less severe, either through medical intervention or other means. For example, Botulinum toxin injections to reduce hypertonia or to increase the active range of movement, tendon releases, orthopaedic implant or corrective surgery, deep brain stimulation to assist posture/stability; or if* * *A Player’s impairment is progressive and has deteriorated to an extent that the Player most likely does not fit his/her current Sport Class anymore.*   ***Making******a******Medical******Review******Request***  *The Medical Review Request must be made by the Player’s Member Association / National Paralympic Committee (NPC). All documents must be in English and include:*   * *This Medical Review Request form, completed legibly;* * *Supporting medical documentation that demonstrates that the Player’s impairment changed after the last Player Evaluation the Player attended; and* * *A non-refundable payment of 100 US$ to the BWF. The Medical Review Request will not be processed until the payment is received.*   ***If the Classifiers are unable to read or understand the information given, the Medical Review Request may be rejected. Any information given must be truthful and accurate.***  *The Medical Review Request must be received by BWF at least 3 months before the next competition where the Player intends to compete.*  *Requests are to be submitted to the following email address:*[*classification@bwf.sport*](mailto:classification@bwf.sport)  ***Consequences******of******a******Medical******Review******Request***  *If the BWF, upon careful review, finds that there could be a change in impairment or activity limitation, the Player’s Sport class status will be changed to Review. Consequently, the Player will be asked to undergo Player Evaluation again at the next opportunity. Please note that re-evaluation does not guarantee that the Sport Class of the Player will change.*  ***Consequences******of******not******making******a******Medical******Review******Request***  *Any failure to make a Medical Review Request in circumstances when it is found that (a) a Medical Review Request should have been made and that (b) the Player knew or should have known that a Medical Review Request should have been made may result in BWF treating that failure as being Intentional Misrepresentation on the part of the Player (see BWF Statutes, Section 5.5.5, Article 7.4).* | |

1. **PLAYER DETAILS**

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| **FAMILY NAME** |  | | |
| **GIVEN NAME** |  | | |
| **BWF PARA BADMINTON LICENCE NUMBER** |  | | |
| **DATE OF BIRTH**  (DD.MM.YYYY) |  | | |
| **NATIONALITY**  (What passport do you hold?) |  | | |
| **MEMBER ASSOCIATION**  (Organisation you represent in Para-Badminton) |  | **GENDER**  (Male / Female) |  |
| **CURRENT SPORT CLASS** |  | **CURRENT CLASS STATUS** |  |

1. **NEXT INTENDED COMPETITION**

**Please write down the exact name of the competition that the Player intends to seek a Medical Review in. You can check the BWF Calendar (**[**linked here**](https://corporate.bwfbadminton.com/para-badminton/calendar/2024/all/0/all/)**) for a list of tournaments with classification. The BWF must receive the Medical Review Request three (3) months in advance of the intended tournament’s competition dates. The BWF reserves the right to decide at which tournament the Medical Review will be conducted.**

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| **COMPETITION NAME** |  |
| **DATE** (DD.MM.YYYY) |  |
| **LOCATION**  (CITY & COUNTRY) |  |

1. **DETAILS OF THE CHANGES OF IMPAIRMENT**(to be completed by the Player)

|  |  |
| --- | --- |
| **Describe the physical changes that have happened to you since your last classification?** |  |
| **What impact have the physical changes above had on your performance and activities of daily living?** |  |
| **How has your sports performance changed since your last classification?** |  |
| **Did you seek treatment to address any physical changes since your last classification? Briefly describe the treatment that you have received.** |  |

1. **TREATMENT DETAILS** (to be completed by a health professional with relevant expertise))

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| --- | --- |
| **Have you treated this Player before? (Yes/No)** |  |
| **If yes, how long have you treated this Player?** |  |
| **Please provide the medical diagnosis for this Player.** |  |
| **Please provide medication details of the Player.** |  |
| **What procedures or surgery has the Player undergo? Provide the dates and details of the procedure(s).** |  |
| **Supporting medical documents:**  **Tick the boxes below if the following documents/reports are provided:**   |  |  | | --- | --- | |  | **Diagnostic imaging AND radiologist report (e.g. : X-ray, MRI, CT scan)**  **Pathology results (e.g. : Blood/urine investigations, genetic study)**  **Neurophysiology study (e.g: EMG, NCS)**  **Biomechanics study**  **Therapist report**  **Other clinical investigation/studies that support the diagnosis and change in impairment.** | |  | |  | |  | |  | |  |   **You may provide the documents above separate to this form.** | |

1. **DESCRIPTION OF THE CHANGE OF IMPAIRMENT**

*(in case of progressive or fluctuating impairments, injuries etc.)*

|  |  |
| --- | --- |
| *If needed, please use additional sheet of paper to describe.* | |
| **DATE OF ONSET** |  |
| **DESCRIPTION OF CHANGE OF IMPAIRMENT AND IMPACT ON PLAYER’S PERFORMANCE** |  |

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| *List of Supporting (additional) Documentation (medical records, imaging etc):*  *\*If needed, please use additional sheet of paper to describe.* |
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1. **DOCTOR DETAILS *(To be filled and signed by doctor)***

|  |  |  |  |
| --- | --- | --- | --- |
| * **I confirm that the** **above** **information** **is** **accurate.** | | | |
| **FULL NAME** |  | | |
| **ADDRESS** |  | | |
| **COUNTRY** |  | |
| **PHONE** |  | **EMAIL** |  |
| **SIGNATURE AND STAMP** |  | | |
| **DATE** |  | | |

1. **MEMBER ASSOCIATION (MA) /NATIONAL PARALYMPIC COMMITTEE (NPC) VERIFICATION**

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| *NPC contact person submitting the Medical Review Request* | | | |
| **MA/NPC** |  | | |
| **NAME** |  | | |
| **FUNCTION** |  | | |
| **PHONE** |  | **EMAIL** |  |
| **SIGNATURE** |  | **DATE** |  |

1. **PLAYER SIGNATURE**

|  |  |  |  |
| --- | --- | --- | --- |
| **SIGNATURE** |  | **DATE** |  |

***If the Player has a legal guardian (as a minor or otherwise), please also include guardian’s name, signature and relation to the Player using the space below.***