



Condition is (please circle all that apply)	Permanent	Stable	Progressive	Fluctuating
Other relevant factors e.g. therapeutic, surgical, or pharmacological interventions				
Impairments arising from the diagnosis	<input type="checkbox"/> muscle power / strength	<input type="checkbox"/> ataxia	<input type="checkbox"/> leg length difference	<input type="checkbox"/> limb deficiency / loss
	<input type="checkbox"/> passive range of motion	<input type="checkbox"/> athetosis	<input type="checkbox"/> short stature (height _____)	
	<input type="checkbox"/> hypertonia	<input type="checkbox"/> Vision	<input type="checkbox"/> Hearing	<input type="checkbox"/> Cognition / memory
Additional health conditions, impairments, or diagnoses	<input type="checkbox"/> Emotional / Behavioral	<input type="checkbox"/> Hypermobility / joint instability	<input type="checkbox"/> Pain	<input type="checkbox"/> Other:

Please print or stamp

Athlete Name	
Physician Name	
License/NPI #	
Address	
Phone/Email	
I have followed this patient for _____ years and confirm that the above information is accurate.	
Signature	
Date	

Information disclosed here and attached will be dealt with confidentially by the USEF and in accordance to the IPC Code of Ethics for Classification.

Please return this form and attached documents to:

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