



## INTERNATIONAL FEDERATION OF SPORT CLIMBING

### IFSC MEDICAL REVIEW REQUEST FORM

#### WHO SHOULD MAKE A MEDICAL REVIEW REQUEST?

A Medical Review Request needs to be submitted for Athletes with Sport Class Status Confirmed or Review with Fixed Review Date, if their impairment and activity limitations are no longer consistent with their current Sport Class.

A medical review request is to be submitted, if

- An athlete's relevant impairment or activity limitation has become less severe, either through medical intervention or other means. Examples of such interventions include, but are not limited to botox injections to reduce hypertonia or to increase the active range of movement, tendon releases, harrington rods or joint fixations to assist posture/stability, or corrective eye surgery; or if
- An athlete's impairment is progressive and has deteriorated to an extent that the athlete 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 Athlete's NPC/NF and comprise

- This medical review request form, completed legibly and in English;
- attached medical documentation that demonstrates that the athlete's impairment changed after the last athlete evaluation the athlete attended; and
- a non-refundable fee of 100 EUR to the IFSC. The medical review request will not be processed until the fee is received.

The medical review request must be received by the IFSC at least 3 months before the next competition where the athlete intends to compete.

Requests are to be submitted to the IFSC exclusively via e-mail: [paraclimbing@ifsc-climbing.org](mailto:paraclimbing@ifsc-climbing.org).

#### CONSEQUENCES OF A MEDICAL REVIEW REQUEST

If the IFSC, upon careful review, is convinced of a change in impairment or activity limitation, the athlete's sport class status will be changed to Review. Consequently the athlete will be asked to undergo Athlete Evaluation again at the next opportunity. Please note, that re-evaluation does not guarantee that the sport class of the athlete will change.

#### CONSEQUENCES OF NOT MAKING A MEDICAL REVIEW REQUEST

Any failure to make a Medical Review Request in circumstances when IFSC determines that (a) a Medical Review Request should have been made and that (b) the Athlete knew or should have known that a Medical Review Request should have been made may result in IFSC treating that failure as being Intentional Misrepresentation on the part of the Athlete (see IFSC Classification Rules - Intentional Misrepresentation).



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## IFSC MEDICAL REVIEW REQUEST FORM

### 1. ATHLETE INFORMATION

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Gender:      Female       Male       Date of Birth  
(dd/mm/yyyy): \_\_\_\_\_

NPC/NF: \_\_\_\_\_ Country: \_\_\_\_\_

Sport Class: \_\_\_\_\_ Sport Class Status: \_\_\_\_\_

Sport: \_\_\_\_\_

### 2. NEXT SCHEDULED COMPETITION

Competition name: \_\_\_\_\_

Date (dd/mm/yyyy): \_\_\_\_\_

Location (city and country): \_\_\_\_\_

### 3. DETAILS ON THE CHANGE IN IMPAIRMENT

To be completed by a health professional with relevant expertise.

#### 3.1. Intervention details (if applicable):

|                                                |  |
|------------------------------------------------|--|
| Date of intervention:                          |  |
| Location where intervention was carried out:   |  |
| Description of intervention:                   |  |
| Reason for intervention and expected outcomes: |  |



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### 3.2. Description of the change of impairment (in case of progressive or fluctuating impairments, injuries etc.):

|                                      |  |
|--------------------------------------|--|
| Date of onset:                       |  |
| Description of change of impairment: |  |

### 3.3. Supporting documentation attached:

|  |
|--|
|  |
|--|

## 4. HEALTH PROFESSIONAL

I confirm that the above information is accurate.

Name: \_\_\_\_\_

Medical Speciality: \_\_\_\_\_

Registration Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Country: \_\_\_\_\_

Tel.: \_\_\_\_\_ E-mail: \_\_\_\_\_

Signature of Medical Practitioner:

Date: \_\_\_\_\_

## 5. NPC/NF VERIFICATION

NPC/NF contact person submitting the medical review request:

|            |       |
|------------|-------|
| NPC/NF:    | _____ |
| Name:      | _____ |
| Function:  | _____ |
| Email:     | _____ |
| Signature: | _____ |
| Date:      | _____ |