

REQUEST FORM FOR VI CLASSIFICATION REVIEW

- To be fully filled in English, in CAPITAL LETTERS, typed or black ink. All frames must be filled.
- Send 3 months prior to VI Classification.
- Attach a medical report to this request.
- An updated MDF must be uploaded in ISAS when sending this request.
- A fee must be paid when sending this request. (Reimbursed if the request is accepted and Class changes) (Bank IBAN for fee payment: 100 EUROS)
- At Classification athlete must show the originals of this REQUEST the MDF and the MEDICAL REPORTED.

Sport: _____

Request for New Classification at: Competition Name: _____

Location (country and city): _____

Classification dates: _____/_____/_____ to _____/_____/_____

Day Month Year Day Month Year

I - ATHLETE INFORMATION (as passport data)

Last name: _____ First name: _____

Gender: Female ☐ Male ☐ Date of Birth: ____/____/____ Nationality: _____

Sport: _____, NPC/NF: _____, ISAS registry: _____, SDMS (IPC): _____

☐ National Paralympic Committee (NPC) or National Federation (NF) certifies that there are no health risks and contra-indication for the athlete to compete at competitive level in the above sport. NPC/NF keeps all the relevant medical and legal documents about it.

Name (stamp)

Signature

_____/_____/_____
Date : Day Month Year

II - PREVIOUS CLASSIFICATIONS

Last National Classification: Year: _____ Class: B1 ☐ B2 ☐ B3 ☐ Other ☐: _____

First International Classifications: New ☐ or Year: _____ Class: B1 ☐ B2 ☐ B3 ☐ NE ☐

Last International Classification: Place: _____, Year: _____, Sport: _____

Actual International Class and Status: New ☐ or Protest / Reclassification accepted ☐ _____, or

Class: B1 ☐ B2 ☐ B3 ☐ Status: Review ☐ (next time) or Review Year ☐ ____; NE ☐ 1st panel;

III – REASON ON THE CHANGES IN IMPAIRMENT

Improvement ☐ Deteriorated ☐

New optical correction / aids used at competition ☐:

Spectacles ☐ Contact lenses ☐ Sun or filter glasses ☐

Optical correction : Right eye: Sph. _____ Cyl. _____ Axis (_____)

Left eye: Sph. _____ Cyl. _____ Axis (_____)

☐ Disease Progression ☐

☐ Medical Treatment ☐

☐ Surgery or Laser Treatment ☐

☐ **Mandatory:** attach a short medical report to this request

Updated MDF needs to be upload in ISAS when sending this request (3 months prior to classification)

Request accepted: ☐ No ☐ Yes

IBSA Medical Director: _____

Signature

_____/_____/_____
Date : Day Month Year

To be filled by NF

To be filled by IBSA

Athlete: last name: _____ first name : _____

IV – FEE**Fee paid:** Amount: _____, currency: _____ Date: ____/____/____Bank accounts: Origin: **NIB:** _____ Transfer to: **NIB:** _____**IBAN:** _____ **IBAN:** _____ **BIC/SWIFT:** _____**BIC/SWIFT:** _____

National Paralympic Committee or National Federation: _____

Name (stamp)

Signature

Date : Day Month Year

Fee received: ☐ No ☐ Yes

IBSA Treasurer :

Signature

Date : Day Month Year

Class changed after classification review: ☐ No (no fee reimbursement) ☐ Yes (fee reimbursement)**Fee reimbursement:** Amount: _____, currency: _____ Date: ____/____/____☐ Sent to bank: **NIB:** _____☐ Paid cash**IBAN:** _____**BIC/SWIFT:** _____

IBSA Treasurer, or _____ :

Name

Signature

☐ Received

Name _____ :

Name

Signature

V – REASSESSMENT RESULTAfter classification review ☐ : **Class changed:** ☐ No (no fee reimbursement) ☐ Yes (fee reimbursement)**CLASS: B1** ☐**B2** ☐**B3** ☐**NE** ☐**CNC** ☐