

Diagnostic Evidence to be attached:

A Medical Diagnostic Report from a Health Professional qualified to examine the above diagnosis, together with the supporting documents (examples below) **MUST** be attached in **English**.

Examples include (but are not limited to):

Eligible Impairment	Underlying Health Condition leading to Eligible Impairment	Documents to support the diagnosis
<input type="checkbox"/> Impaired Muscle Power	<input type="checkbox"/> Spinal cord injury <input type="checkbox"/> Muscular dystrophy <input type="checkbox"/> Post-polio syndrome <input type="checkbox"/> Spina bifida <input type="checkbox"/> Other _____	<input type="checkbox"/> Medical Report <input type="checkbox"/> Recent Muscle Strength Testing results (Oxford scale) <input type="checkbox"/> Electromyography (EMG) report <input type="checkbox"/> Magnetic Resonance Imaging (MRI) report <input type="checkbox"/> X-rays <input type="checkbox"/> Biopsy <input type="checkbox"/> Other _____
<input type="checkbox"/> Limb Deficiency (amputation)	<input type="checkbox"/> Absence of bones or joints as a consequence of trauma or illness <input type="checkbox"/> Congenital limb deficiency <input type="checkbox"/> Other _____	<input type="checkbox"/> Medical report <input type="checkbox"/> X-rays <input type="checkbox"/> Photographs <input type="checkbox"/> Other _____
<input type="checkbox"/> Leg Length Difference	<input type="checkbox"/> Dysmelia <input type="checkbox"/> Trauma <input type="checkbox"/> Other _____	<input type="checkbox"/> Medical report <input type="checkbox"/> X-rays <input type="checkbox"/> Photographs <input type="checkbox"/> Other _____
<input type="checkbox"/> Hypertonia <input type="checkbox"/> Ataxia <input type="checkbox"/> Athetosis	<input type="checkbox"/> Cerebral palsy <input type="checkbox"/> Traumatic brain injury <input type="checkbox"/> Stroke <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Other _____	<input type="checkbox"/> Medical report <input type="checkbox"/> Spasticity Grading (Ashworth Scale) <input type="checkbox"/> Cerebral MRI/CT scan <input type="checkbox"/> Other _____
<input type="checkbox"/> Impaired Passive Range of Movement	<input type="checkbox"/> Arthrogyrosis <input type="checkbox"/> Joint contracture <input type="checkbox"/> Trauma affecting a joint <input type="checkbox"/> Other _____	<input type="checkbox"/> Medical report <input type="checkbox"/> X-rays <input type="checkbox"/> Photographs <input type="checkbox"/> Goniometric measures <input type="checkbox"/> Other _____

FIS holds the right to request additional diagnostic evidence, as per article 7.5 and 7.6 in the FIS Para Nordic Skiing Classification Rules and Regulations, if FIS at its sole discretion considers the Medical Diagnostic Form and/or the Diagnostic Information to be incomplete or inconsistent.

Treatment History:												
Regular Medication – List dosage and reason:												
<p>Presence of additional medical conditions/diagnoses:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; vertical-align: top; padding: 2px;"><input type="checkbox"/> Vision impairment</td> <td style="width: 33%; vertical-align: top; padding: 2px;"><input type="checkbox"/> Impaired respiratory function</td> <td style="width: 33%; vertical-align: top; padding: 2px;"><input type="checkbox"/> Joint Hypermobility/ instability</td> </tr> <tr> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Intellectual impairment</td> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Impaired metabolic functions</td> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Impaired muscle endurance (e.g., Chronic fatigue)</td> </tr> <tr> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Hearing impairment</td> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Impaired cardiovascular functions</td> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Other: _____</td> </tr> <tr> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Psychological diagnoses</td> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Pain</td> <td></td> </tr> </table> <p>Describe:</p>	<input type="checkbox"/> Vision impairment	<input type="checkbox"/> Impaired respiratory function	<input type="checkbox"/> Joint Hypermobility/ instability	<input type="checkbox"/> Intellectual impairment	<input type="checkbox"/> Impaired metabolic functions	<input type="checkbox"/> Impaired muscle endurance (e.g., Chronic fatigue)	<input type="checkbox"/> Hearing impairment	<input type="checkbox"/> Impaired cardiovascular functions	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Psychological diagnoses	<input type="checkbox"/> Pain	
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<input type="checkbox"/> I confirm that the above information is accurate	
Doctors Name:	
Medical Specialty:	Registration Number:
Address:	
City:	Country:
Phone:	E-mail:
Signature:	Date: