Challenged Athletes Foundation – Medical Verification of Disability Form

Please complete the questions below to indicate the named individual's permanent physical disability by selecting one or more of the following conditions that verify the individual's eligibility for CAF support.

- ○ **Ataxia** – lack or coordinated muscular movements due to a neurological condition – cerebral palsy, brain injury, multiple sclerosis (MS), muscular dystrophy (MD), or similar condition.
- ○ **Athetosis** – unbalanced, involuntary movement or difficulty maintaining a symmetrical posture due to a neurological condition – cerebral palsy, brain injury, MS, or stroke.
- ○ **Hypertonia** – abnormal increase in muscle tone and reduced ability of a muscle to stretch due to damage to the central nervous system – cerebral palsy, brain injury, stroke.
- ○ **Impaired Muscle Power** – reduced or absent voluntary contracture of muscles to move or generate force – spinal cord injury, MS, MD, post-polio syndrome, spina bifida, peripheral nerve injuries. **Chronic back pain and spinal stenosis are not eligible conditions.**
- ○ **Impaired Passive Range or Movement** – permanent restriction of movement in one or more joints – arthrogryposis, contracture or trauma affecting a joint. **Hypermobility of joints, joint instability, arthritis, and degenerative disc disease are not eligible conditions.**
- ○ **Leg Length Difference** – difference in length of leg(s) due to disturbance of limb growth or trauma.
- ○ **Limb Deficiency** – total or partial absence of bones or joints due to trauma, illness, or congenital limb deficiency. For the hand – minimum three missing digits on one hand.
- ○ **Short Stature** – reduced standing height and reduced length of bones – achondroplasia, growth hormone dysfunction, osteogenesis imperfecta.
- ○ **Visual Impairment** – reduced or no vision due to damage to the eye structure, optical nerves, optical pathways, or visual cortex of the brain.

Medical Professional Information

Full Name: ______________________________ Email: ____________________________________

Organization/Affiliation: _______________________________ Phone: _____________________

Role of Medical Professional (must be one of the following):

__Physician __Occupational Therapist __Nurse Practitioner __Prosthetist

__Physician Assistant __Physical Therapist __Therapeutic Recreation Specialist

Patient Information

Full Name: ____________________________________

Patient's Medical Diagnosis: ____

Please specifically describe how the patient's physical disability affects their mobility, neuromuscular control, balance, or activities of daily living?

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Medical Professional's Signature & Credentials: ____

Date: __________________________

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