



Türkiye Taekwondo Federasyonu
Turkish Taekwondo Federation

P30-P50-P70 SINIFLANDIRMA İÇİN GEREKLİ BELGELER

NÖROLOJİK BOZUKLUĞU OLAN SPORCULAR -HİPERTONİ-SPASTİSİTE-ATHETOZ-DİSTONİ-ATAKSİ (P30)

- **Sporcu için kriter:** Başlıkta ismi geçen yetersizliklerden birine (Merkezi Sinir Sistemi (MSS) ile ilgili bir soruna (örneğin: serebral palsi, beyin yaralanması veya omurilik yaralanması) sahip olmalıdır.
- WT MDF (*Ek bakınız*)
- Tıbbi Rapor: Sporcunun nörolojik durumunu göstermelidir. (Örn: CP, ataksi, distrofi, vb. tanı belgeleri). Raporda durumun kalıcı olduğu belirtilmeli, gerekli tanı bulguları eklenmelidir (EMG, MR, tomografi, genetik testi vb.).
- Fotoğraf (Duvar önünde bütün vücudunu gösterir şekilde, anatomik pozisyonda ve çorapsız)

YARDIMCI CİHAZ-TEKERLEKLİ SANDALYE- SAHİP SPORCULAR (P50)

- **Sporcu için kriter:** Aşağıdaki yetersizliklerden birine sahip olmalıdır.
 - Ekstremiteler yetersizliği: Travma veya kanser gibi amputasyonlar ya da doğuştan malformasyonlar, örn. dismeli).
 - Kas gücü kaybı: (Periferik Sinir Sistemi “PNS” yaralanmaları örn. Brakial Pleksus veya Merkezi Sinir Sistemi “CNS” durumları örn. beyin veya omurilik yaralanması ile ilgili olabilir).
 - Pasif Hareket Açısı kısıtlılığı: Örn: eklem kontraktürü veya ankiloz).
 - Nörolojik durumlar: Hipertoni / Spastisite, Athetoz, Distoni veya Ataksi vb.
- WT MDF: Kullanılan yardımcı cihazın türü belirtilmelidir. (*Ek bakınız*)
- Tıbbi Rapor: Sporcunun ayakta durma dengesini sağlamak için yardımcı cihazlara veya günlük yaşamda tekerlekli sandalye kullanımına ihtiyaç duyduğunu göstermelidir. (Örn: CP, ataksi, distrofi, vb. tanı belgeleri). Raporda durumun kalıcı olduğu belirtilmeli, gerekli tanı bulguları eklenmelidir (EMG, MR, tomografi, genetik testi vb.).
- Fotoğraf (Duvar önünde bütün vücudunu gösterir şekilde, yardımcı cihazla birlikte)

KISA BOYLU SPORCULAR (P70)

- WT MDF: Sporcunun herhangi bir gövde korsesi veya cihazı kullanıp kullanmadığı belirtilmelidir. *(Ek bakınız)*
- **Erkek sporcu için kriterler:** Ayakta boy uzunluğu ≤ 145 cm, kol uzunluğu ≤ 66 cm, ayakta boy uzunluğu ile kol uzunluğu toplamı ≤ 200 cm; **Kadın sporcu için kriterler:** Ayakta boy uzunluğu ≤ 137 cm, kol uzunluğu ≤ 63 cm, ayakta boy uzunluğu ile kol uzunluğu toplamı ≤ 190 cm olmalıdır.
- Fotoğraf (Duvar önünde bütün vücudunu gösterir şekilde ve anatomik pozisyonda, (varsa) gövde korsesiyle beraber ve korsesiz olarak)

TÜM BELGELER İNGİLİZCE OLARAK SUNULMALIDIR

MDF, raporlar ve tüm belgeler PDF formatında taranmalıdır.

Doruk Ekin Fırat

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+90 312 310 88 16 - 1642 (Dahili)

Türkiye Taekwondo Federasyon



EN

- This form must be completed in ENGLISH by the Member National Association (MNA)'s physician or team doctor.



- Must be submitted by REGISTRATION DEADLINE of the event through <https://db.ipc-services.org/wtcs/app/login>



- Must have MEDICAL REPORT in ENGLISH submitted to WTCS.



- PHOTO of the athlete is MANDATORY.
- See PHOTO GUIDE next page
- Must be submitted also to WTCS under supporting documents.



- The Assessment group may ask for further documents to be submitted depending on the individual athlete's health condition and impairment.



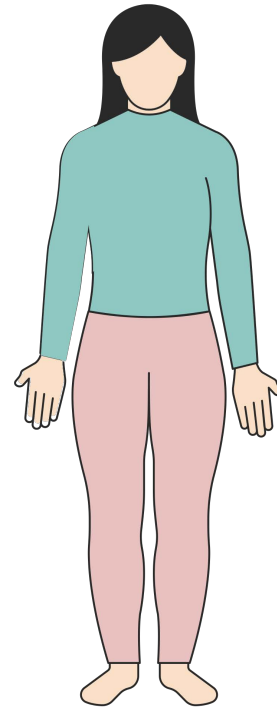
- For further information, please contact Para Taekwondo Department at classification@worldtaekwondo.org

PHOTO GUIDE

Medical Diagnostic Form
For athletes with Neurological impairments



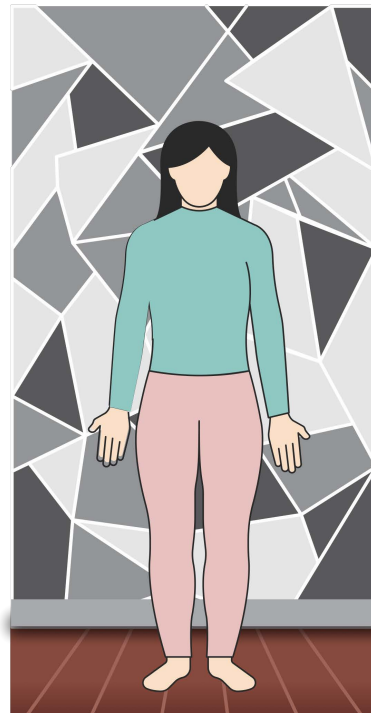
Anatomical position
& full body photo



Clear background



Part body photo



Background



Athlete Information

First Name:	Last Name:
Date of Birth <i>dd/mmm/yyyy</i> :	Gender:
Discipline:	How long competing:
Member National Association:	WT License:

Eligible Impairment (s):

Hypertonia/ Spasticity	Athetosis	Dystonia	Ataxia
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Underlying Health Condition:

Brain injury	Brain stroke	Spinal cord injury	Cerebral Palsy
Others, specify:			

Details of the impairment *(Please give details of the medical condition, severity and how many limbs affected):*

Health condition is:
If acquired, age of onset:
Other health conditions:
Medication (s):

Declaration signed by MNA physician or Team doctor:

I confirm that the above information is accurate.			
Name:			
Health care profession:			
Professional registration number:			
Address:			
City:		Country:	
Phone:		E-mail:	
Date <i>dd/mmm/yyyy</i> :		Signature:	

CHECKLIST

Tick all applicable options

 Medical report *(must contain -clear diagnosis -severity -which limbs are affected -how stable is the condition.*

Others, please specify:

INSTRUCTION

Medical Diagnostic Form
For athletes with Assistive Devices



EN

- This form must be completed in ENGLISH by the Member National Association (MNA)'s physician or team doctor.



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- PHOTO of the athlete is MANDATORY.
- See **PHOTO GUIDE** next page.
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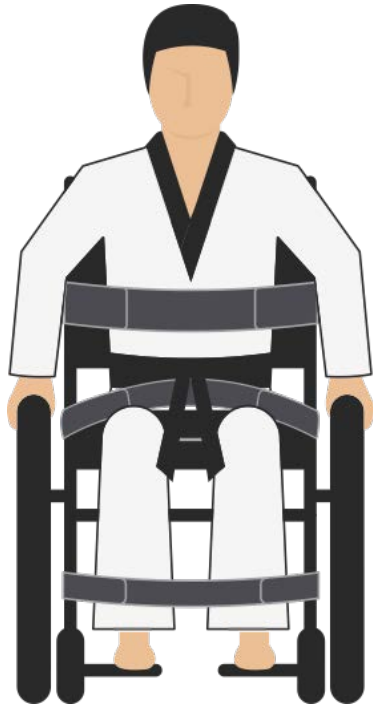
- The Assessment group may ask for further documents to be submitted depending on the individual athlete's health condition and impairment.



- For further information, please contact Para Taekwondo Department at classification@worldtaekwondo.org

PHOTO GUIDE

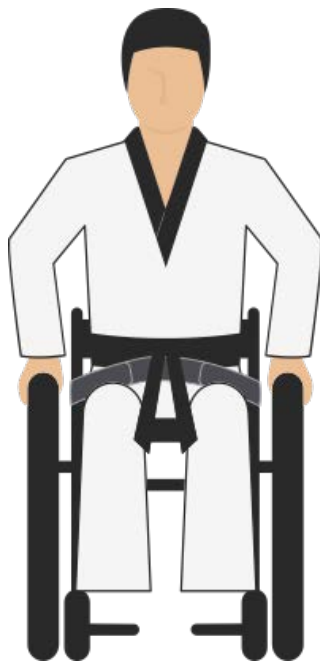
Medical Diagnostic Form
For athletes with Assistive Devices



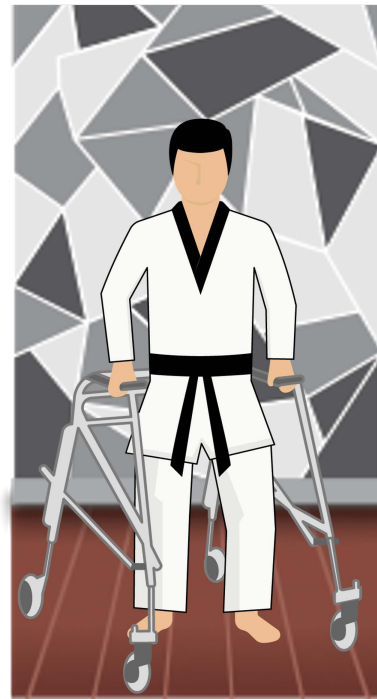
Frontal view, clear background
Wheelchair straps showing ✓



Impaired limbs
showing ✓



Impaired limb
not showing ✗



Background ✗

Athlete Information

First Name:	Last Name:
Date of Birth <i>dd/mmm/yyyy</i> :	Gender:
Discipline:	How long competing:
Member National Association:	WT License:

Eligible Impairment (s):

Hypertonia/ Spasticity	Athetosis	Dystonia
Limb deficiency	Impaired Muscle Power	Impaired Passive Range of Movement

Underlying Health Condition:

Brain or spinal cord injury	Brain stroke	Peripheral nerve injury	Cerebral Palsy
Amputation	Dysmelia/malformation	Joint contracture	Polyomyelitis
Others, specify:			

Details of the impairment *(Please give details of the medical condition, severity and how many limbs affected):*

Health condition is:
If acquired, age of onset:
Other health conditions:
Medication (s):

Declaration signed by MNA physician or Team doctor:

I confirm that the above information is accurate.			
Name:			
Health care profession:			
Professional registration number:			
Address:			
City:		Country:	
Phone:		E-mail:	
Date <i>dd/mmm/yyyy</i> :		Signature:	

CHECKLIST

Tick all applicable options

 Medical report *(must contain -clear diagnosis -severity -which limbs are affected -how stable is the condition.*

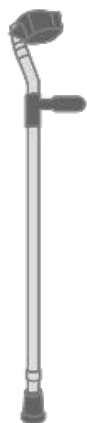
Others, please specify:

ASSISTIVE DEVICES

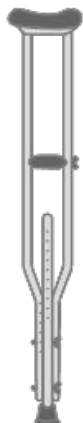
Medical Diagnostic Form
For athletes with Assistive Devices



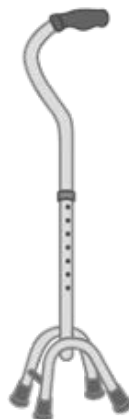
Please tick which Assistive Device your athlete uses:



Forearm crutch



Auxiliary crutch



Four leg pyramid cane



Crab foot cane



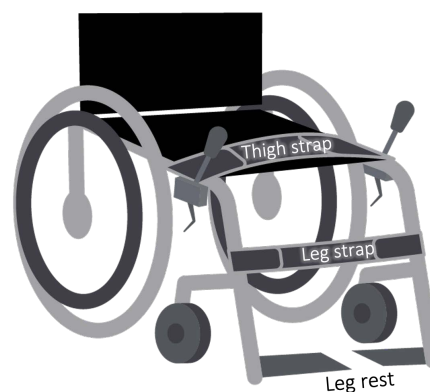
Reverse Walker



Anterior Walker



Long back wheelchair



Short back wheelchair

INSTRUCTION

Medical Diagnostic Form For athletes with Physical impairments



EN

- This form must be completed in ENGLISH by the Member National Association (MNA)'s physician or team doctor.



- Must be submitted by REGISTRATION DEADLINE of the event through World Taekwondo Classification System (WTCS) <https://db.ipc-services.org/wtcs/app/login>



- Any supporting documents (*e.g. photo or medical report*) must be submitted also to WTCS, and all documents PRINTED and BROUGHT with the athlete during the athlete evaluation session.



- PHOTO of the athlete is MANDATORY.
- See PHOTO GUIDE next page.
- Must be submitted also to WTCS under supporting documents.



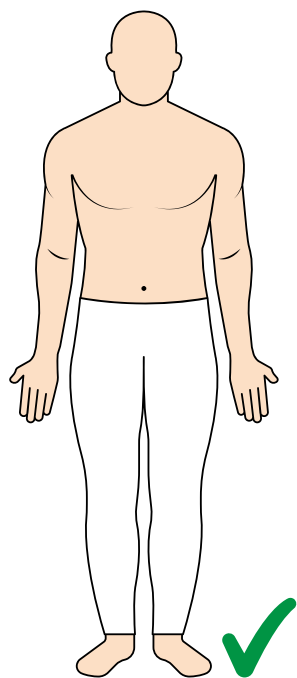
- The Assessment group may ask for further documents to be submitted depending on the individual athlete's health condition and impairment.



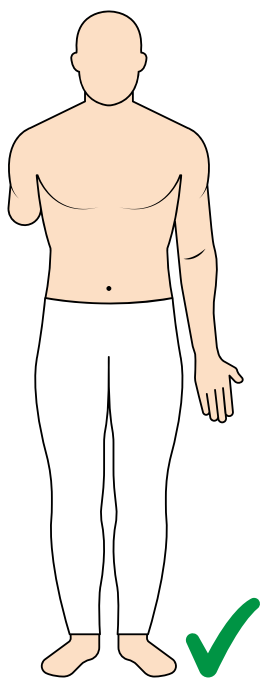
- For further information, please contact Para Taekwondo Department at classification@worldtaekwondo.org

PHOTO GUIDE

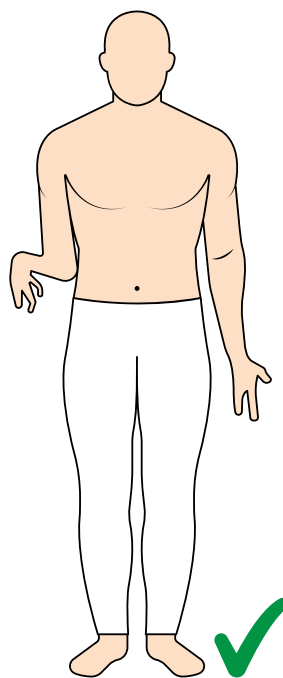
Medical Diagnostic Form
For athletes with Physical impairments



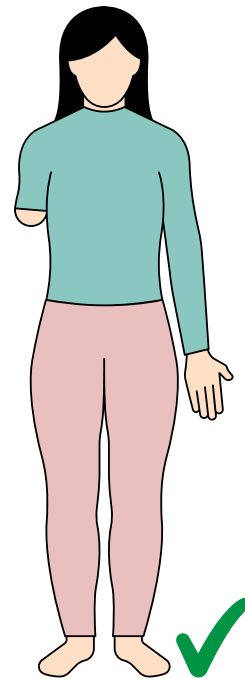
Anatomical position
& white background



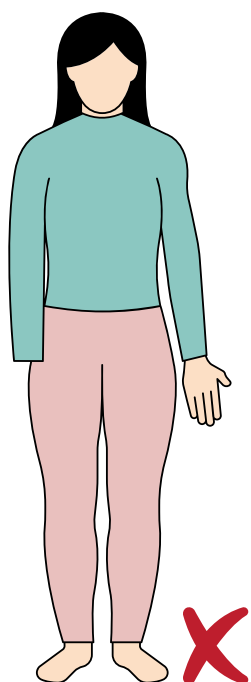
Amputation
or Dysmelia



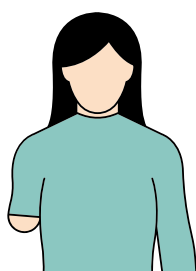
Arm contracture
stretched as possible



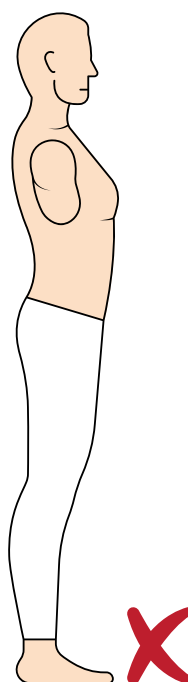
If wearing T-shirt,
affected arm(s) showing



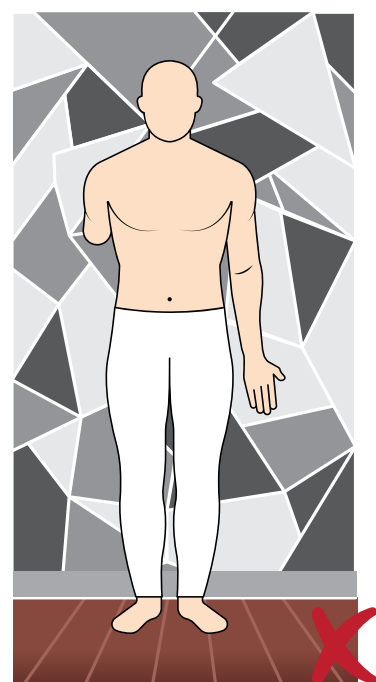
Affected arm(s)
not showing



Part body photo



Sideway photo



Background


Athlete Information

First Name:	Last Name:
Date of Birth dd/mmm/yyyy:	Gender:
Discipline:	How long competing:
Member National Association:	WT License:

Eligible Impairment type(s):

Limb deficiency	Impaired muscle power	Impaired passive range of movement
Leg length difference	Short Stature	

Underlying Health Condition:

Amputation	Dysmelia/ malformation	Brachial plexus	Brain or Spinal cord injury
Joint contracture	Peripheral Nerve injury	Poliomyelitis	Dwarfism
Others, please specify:			

Details of the impairment *(Please give details of the history how the impairment happened):*

Health condition is:		If acquired, age of onset:	
Using any adaptive devices		If yes, please describe:	
Anticipated future procedure(s):			
Medication (s):			

Declaration signed by MNA physician or Team doctor:

I confirm that the above information is accurate.			
Name:			
Health care profession:			
Professional registration number:			
Address:			
City:		Country:	
Phone:		E-mail:	
Date dd/mmm/yyyy:		Signature:	

CHECKLIST
Tick all applicable options

Photo

Medical report

Electromyograph "EMG"

Nerve conduction test

Others, please specify: