

**USA WHEELCHAIR SOFTBALL
MINIMAL DISABILITY CERTIFICATION FORM**

NAME: _____
Last First Middle Nickname

ADDRESS: _____
Street City State Zip

AGE: _____ BIRTHDATE: _____ GENDER: _____

TEAM: _____

I desire the opportunity to participate in USA Wheelchair Softball. I shall abide by the rules and regulations, the purposes and principles of USA Wheelchair Softball USA Wheelchair Softball. I recognize the good I can derive from fair and equitable participation in a properly administered program of wheelchair softball.

SIGNATURE OF PARENT/GUARDIAN

PLAYER APPLICANT SIGNATURE

DISABILITY CERTIFICATION:

I certify that the above player applicant was examined by myself on this date and meets the ELIGIBILITY criteria below:

USA Wheelchair Softball Eligibility Criteria:

A wheelchair softball player must have a **permanent physical disability which consistently reduces the function of the lower limbs** to a degree where they cannot run, pivot or jump at the speed and with the control, safety, stability and endurance required to play running basketball as an able bodied player. The disability must be such that it can be objectively verified by acknowledged medical and/or paramedical investigations such as measurement, X-ray, CT, MRI, etc.. Persons who have had hip or knee joint replacements and have provided confirmation of the relevant surgery from their attending physician or surgeon and supporting X-rays/ scans are deemed to have met the eligibility criteria. Findings such as soft tissue contracture, edema or disuse atrophy, or symptoms such as pain or numbness without other objective findings shall not be considered a permanent lower extremity disability. For the purpose of USA Wheelchair Softball Classification, degrees of pain and/or numbness are not considered measurable and permanent disabilities. An otherwise able-bodied player with a temporary disability, (involving for instance, the rehabilitative period following a surgery or a fracture) is not considered eligible, as the player would be expected to regain function within normal limits.

Minimal amputation is the First Ray of the foot.

Permanent Lower Extremity Disability: _____

Diagnosis _____

Signature Physician / NPI number

Name: _____

Address: _____

Phone: _____

PLAYER CERTIFICATION: (RECORDING PURPOSE ONLY)

Signature of Team Representative

Date

Signature of USA Wheelchair Softball Commissioner

Date