



2009 ITF QUAD REGISTRATION FORM

TO BE COMPLETED IN THE ENGLISH LANGUAGE

記入例

PLEASE PRINT IN BLACK INK ENSURING ALL INFORMATION IS CLEAR

PART 1: PLAYER INFORMATION

名 FIRST NAME: TARO 姓 FAMILY NAME: NIPPON MALE FEMALE

Home address: 1-23-4 MIDORI-KU (丁目 番地 号、町名)
Street Address

NAGOYA-SHI City (市) AICHI State (県) JAPAN Country (国) 458-0924 Zip (Postal Code) (郵便番号)

電話 Telephone: +81 52 1234 5678 携帯 Mobile: +81 90 1234 5678 Fax: +81 52 1234 5678

Email address: taro_nippon@aaa.com (Please print CLEARLY)

誕生日: (日 月 西暦年) 07 July 1956 障害名 Nature of Disability: spinal damage C8

事故、障害が始まった日: (日 月 西暦年) 07 July 2000
Date of Accident or onset of Disability:

国際協会の名前 Name of National Association: Japan Wheelchair Tennis Association

国籍所有国 Country of Citizenship: JAPAN 国籍 Nationality: Japanese

以前に車いすテニスのクアッド部門に申請したことがありますか? はい/いいえ
Have you previously applied for quad status in wheelchair tennis? Yes/ No

CONDITIONS OF PARTICIPATION

- (i) I, the undersigned Player, confirm that I have read and have understood the provisions contained in the Wheelchair Tennis Handbook ("Handbook") (a copy of which is also on the website) and the Rules of Tennis ("Rules"). I hereby agree to abide by the Handbook and Rules and any modifications thereof, including the Code of Conduct.
- (ii) I hereby further agree to be bound by any and all decisions made by the ITF Wheelchair Tennis Committee and/or the ITF under the Handbook, Rules and/or Code of Conduct. I further accept that I may be subject to penalties (financial or otherwise) if I fail to comply with the provisions of the Handbook, Rules and/or Code of Conduct. I agree to discharge any such financial penalties, which may be imposed on me by the ITF Wheelchair Tennis Committee.
- (iii) I hereby acknowledge that Wheelchair Tennis is a physically demanding sport and that it is my responsibility to ensure that I am physically and medically fit to participate in any ITF sanctioned Wheelchair Tennis event.
- (iv) I further acknowledge that participation in Wheelchair Tennis carries with it inherent risks of injury and/or other damage or loss to person and/or property. I acknowledge that my participation in any ITF sanctioned Wheelchair Tennis event is on a voluntary and informed basis with respect to such risks and therefore that I am personally assuming such risks. It is my responsibility to insure against such risks should I choose to do so and not the responsibility of the ITF and/or ITF Wheelchair Tennis Committee. In any event, I shall have no recourse against the ITF and/or the ITF Wheelchair Tennis Committee in the event that I do suffer such injury and/or other damage or loss to person or property.
- (v) I understand and accept that when entering into any ITF sanctioned Wheelchair Tennis event, including the Wheelchair Tennis Tour, the World Team Cup and Paralympic Games, neither the ITF Wheelchair Tennis Committee, the ITF nor any of their respective officers, agents or employees shall be liable to me in respect of my death, personal injury, loss of, or damage to property that I may sustain, however caused, while travelling to and from and/or participating in any ITF sanctioned Wheelchair Tennis event, save where such injury and/or loss was incurred as a direct result of negligent acts or omissions on the part of the ITF and/or ITF Wheelchair Tennis Committee or any of their respective officers, agents or employees.
- (vi) I further understand and accept that my participation in any ITF sanctioned wheelchair tennis event shall also represent definitive proof of my acknowledgement and acceptance of other relevant consents and agreements herein.

PART 1 CONTINUED
QUAD ELIGIBILITY

I acknowledge and accept that compliance with the eligibility rules is fundamental to maintaining the integrity of wheelchair tennis and that it is necessary and reasonable for the ITF to verify my eligibility to participate and for the ITF and other relevant committees/personnel to have access to my medical details for such purposes.

(i) I hereby confirm that I meet at least one of the functional disability criteria listed below, **(must tick all that apply, at least one)**:

- Reduced motor function necessary to perform an overhead service, or;
- Reduced motor function necessary to perform a forehand and backhand, or;
- Reduced motor function necessary to manoeuvre a manual wheelchair or;
- Inability to grip the racquet necessitating the need for taping and/ or an assistive device in order to play.

(ii) I agree to inform the ITF if my level of functional disability materially improves

(iii) I agree that if the ITF Wheelchair Tennis Medical Commission and/or classifiers require additional evidence and/or information and/or assistance for the purposes of assessing my quad eligibility (including the provisional medical evidence or otherwise), that I shall provide and/or facilitate the provision of such evidence, information and/or assistance at my expense and within the time limit directed by the Commission and/or classifier as the case may be. I further acknowledge and accept that a failure to provide such information, evidence and/or assistance within the time limit, may delay the determination of my quad eligibility and that during such period I shall not be eligible to play in the quad division.

(iv) I agree and consent to my doctor and/or relevant persons and/or entities disclosing medical information and documentation to the ITF and its relevant Committees and/or relevant persons for the purposes of assessing and/or reviewing my eligibility to play in the Quad Main Draw and other relevant matters and that I agree that this information and that set out above may be used for these purposes. I knowingly waive any applicable duties of confidentiality in this regard.

ITF TENNIS ANTI-DOPING PROGRAMME 2009 PLAYER CONSENT AND AGREEMENT

I, the undersigned Player acknowledge that I have received and have had an opportunity to read the ITF Tennis Anti-Doping Programme (the "Programme"). I confirm that I understand the provisions of the Programme including what constitutes a Doping Offence thereunder, and I hereby consent and agree:-

1. to comply with and be bound by all of the provisions of the Programme;
2. that any dispute arising out of any decision made by the Anti-Doping Tribunal or any dispute under or in connection with the Programme after exhaustion of the Programme's Anti-Doping Tribunal process and any other proceedings expressly provided for in the Programme, shall be submitted exclusively to the Appeals Arbitration Division of the Court of Arbitration for Sport ("CAS") for final and binding arbitration in accordance with the Code of Sports – Related Arbitration.
3. I further consent and agree that:-
 - a. the decisions of CAS shall be final, non-reviewable, non-appealable and enforceable; and
 - b. I shall not institute any claim, arbitration, lawsuit or litigation or seek any form of relief in any other court or tribunal.

I hereby confirm that I have read, understood and agree to be bound by the terms of this Player Consent Agreement.

PLAYER AGREED AND ACCEPTED PART 1:

TARO NIPPON

活字体名前
(Print Name)

日付：日 月 西曆年
DATE: 05 May 2009

TARO NIPPON

署名
(Sign Name)

重要 - 黒インクではっきり書いてください

選手名:

IMPORTANT - PLEASE PRINT CLEARLY IN BLACK INK

NAME OF PLAYER TARO NIPPON

PART 2: DOCTOR INFORMATION (3 PAGES TO BE COMPLETED AS FULLY AS POSSIBLE)

医師名

医師情報: できるだけ3ページ全部を医師に記入してもらってください。

Doctor's Name:

First

Last (Family Name)

Office Address:

City

State

Country

Zip (Postal Code)

Telephone:

Mobile:

Fax:

Email address:

Licensing Body:

Registration/License number (or equivalent):

Board Certified: Yes

No

Medical Specialty (please circle):

Neurology / Neurosurgery / Spinal Orthopaedic Surgery / Physiatry or Physical Rehabilitation / Other (please specify)

Player's Medical Disability (please tick all that apply):

The player must have a permanent neuromuscular dysfunction of at least three extremities with a diagnosis which includes at least one of the following:

- neurological deficit at the C8 level or proximal, with associated loss of motor function
- Upper extremity amputation
- Upper extremity phocomelia
- Upper extremity myopathy or muscular dystrophy
- Functional disabilities in one or both upper extremities equivalent to the above disabilities

Give a detailed description of impairment, including motor function using 5-point scale on this form. Please attach any supporting documentation, e.g., consult reports, imaging studies, operative reports.

PLEASE LIST UPPER EXTREMITY STRENGTH USING 5-POINT SCALE

(0 = no movement; 1=contraction only; 2=cannot resist gravity; 3=resists gravity; 4=resists moderate force; 5=normal)

	R	L
Shoulder Abd		
Shoulder Add		
Shoulder Ext		
Shoulder Flex		
Scapular Protract		
Scapular Retract		
Shoulder IR		
Shoulder ER		
Elbow Flex		
Elbow Ext		
Pronation		
Supination		
Wrist Ext		
Wrist Flex		
Ulnar deviation		
Radial deviation		
Finger extension		
Finger flexion		
Dorsal Abduction		
Palmar Adduction		

Thumb Abduction		
Thumb Adduction		
Thumb Extension		
Thumb Flexion		
Thumb Opposition		

DIAGNOSIS (PLEASE TICK ALL THAT APPLY)

- Spinal Cord Injury**
- | | | | |
|---|-----------------------------------|-------------------------------------|--------------------------|
| <input type="checkbox"/> Lumbar | <input type="checkbox"/> Complete | <input type="checkbox"/> Incomplete | <input type="checkbox"/> |
| <input type="checkbox"/> High Thoracic (T5 or higher) | <input type="checkbox"/> Complete | <input type="checkbox"/> Incomplete | <input type="checkbox"/> |
| <input type="checkbox"/> Low Thoracic (T6 or lower) | <input type="checkbox"/> Complete | <input type="checkbox"/> Incomplete | <input type="checkbox"/> |

- Lower Extremity Amputation**
- Both Legs**
- | |
|--|
| <input type="checkbox"/> Both above the knee |
| <input type="checkbox"/> One above, one below knee |
| <input type="checkbox"/> Both below the knee |
- One Leg**
- | |
|---|
| <input type="checkbox"/> Above the knee |
| <input type="checkbox"/> Below the knee |

- Ankylosis / Arthrosis**
- | | | |
|---------------------------------|--------------------------------|-------------------------------|
| <input type="checkbox"/> Hips | <input type="checkbox"/> right | <input type="checkbox"/> left |
| <input type="checkbox"/> Knees | <input type="checkbox"/> right | <input type="checkbox"/> left |
| <input type="checkbox"/> Ankles | <input type="checkbox"/> right | <input type="checkbox"/> left |

Other
Describe

.....

.....

Does the Athlete have permanent neuromuscular dysfunction in at least three extremities?

Yes No

Does the Athlete have limited trunk function?

Yes No

If yes, to what level?

Diagnosis (please tick all that apply)

- Spinal cord lesion**
- | | | |
|--------------------------------------|-------------------------------------|------------------------------------|
| <input type="checkbox"/> C8 or lower | <input type="checkbox"/> unilateral | <input type="checkbox"/> bilateral |
| <input type="checkbox"/> C7 or lower | <input type="checkbox"/> unilateral | <input type="checkbox"/> bilateral |
| <input type="checkbox"/> C6 or lower | <input type="checkbox"/> unilateral | <input type="checkbox"/> bilateral |
| <input type="checkbox"/> C5 or lower | <input type="checkbox"/> unilateral | <input type="checkbox"/> bilateral |

- Upper Extremity Amputation**
- | | | |
|---|-------------------------------------|------------------------------------|
| <input type="checkbox"/> MCP* or distal | <input type="checkbox"/> unilateral | <input type="checkbox"/> bilateral |
|---|-------------------------------------|------------------------------------|

Below elbow unilateral bilateral

Above elbow unilateral bilateral

*MCP – metacarpo-phalangeal

Poliomyelitis

Upper Extremities Poliomyelitis

proximal unilateral bilateral

distal unilateral bilateral

Lower Extremities Poliomyelitis

unilateral bilateral

Phocomelia

Upper Extremities Phocomelia

unilateral bilateral

Lower Extremities Phocomelia

unilateral bilateral

Myopathy or Muscular Dystrophy

Upper Extremities

proximal unilateral bilateral

distal Unilateral bilateral

Lower Extremities

unilateral bilateral

Permanent Neuropathy (eg Guillain Barre, Significant Plexus Lesion, Significant Peripheral Neuropathy)

Upper Extremities

proximal unilateral bilateral

distal unilateral bilateral

Lower Extremities

unilateral bilateral

EXTRA SPACE FOR FURTHER DETAILED INFORMATION

I hereby declare that:

- (i) all information, documentation and medical evidence supplied is correct and accurate
- (ii) the condition of the player is permanent

登録医師名
Name of Registered Doctor

登録医師署名
Signature of Registered Doctor

患者名
Name of Patient

日付
Date

PLEASE NOTE THAT THIS SECTION MUST BE COMPLETED BY THE MEMBER NATION BEFORE SUBMITTING TO THE ITF

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PLEASE PRINT CLEARLY IN BLACK INK

選手名: TARO NIPPON
NAME OF PLAYER

国際協会 (ITFに加入している加盟国であること)

PART 3: NATIONAL ASSOCIATION [MUST BE AFFILIATED MEMBER NATION TO THE ITF]

国際協会
National Association: 以下の医師名以外はJWTAで記入します。

連絡先の名前
Contact Name: _____

住所
Address: _____
Street Address

_____ City _____ State _____ Country _____ Zip (Postal Code)

Telephone: _____ Mobile: _____ Fax: _____

Email address: _____ PLEASE PRINT CLEARLY

I hereby declare that:

- (i) To my knowledge the information stated in part 1 and 2 is correct
- (ii) Doctor 医師名 is a registered doctor in our country

NATIONAL ASSOCIATION AGREED AND ACCEPTED PART 3:

_____ (Print Name) DATE: _____

_____ (Sign Name)

Please send the completed and signed registration form and any supporting doctor's forms to:

**ITF Ltd
Wheelchair Tennis Department
Bank Lane
Roehampton
London SW15 5XZ
Great Britain
Fax No: +44 (0) 208 392 4741**