Challenged Athletes Foundation - Medical Verification of Disability Form

To receive support and become part of the CAF community, we require all individuals with permanent physical disabilities to submit a document or letter from a medical professional that verifies their physical impairment.

Medical Professional Information

Full Name: _____ Email: _____

Organization/Affiliation: _____ Phone: _____

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

- ☐ Physician
- ☐ Physician Assistant
- ☐ Nurse Practitioner
- ☐ Physical Therapist
- ☐ Occupational Therapist
- ☐ Recreation Therapist
- ☐ Prosthetist

Patient Information

Full Name: _____

Patient's Medical Diagnosis: _____

What is the patient's physical disability? Please indicate the most appropriate choice below:

- ☐ Impaired Muscle Power
- ☐ Impaired Passive Range of Movement
- ☐ Limb Deficiency
- ☐ Leg Length Difference
- ☐ Short Stature
- ☐ Hypertonia
- ☐ Ataxia
- ☐ Athetosis
- ☐ Visual Impairment

How does the patient's physical disability affect their mobility, neuromuscular control, balance, or activities of daily living? Please be specific:

_____

_____

_____ _____

Signature and credentials Date