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|  New Logo | International BBowl & Jackwls for the Disabled Inc.Registered Office: 14 Melbourne Street, North Adelaide 5006, AustraliaABN 86 790 300 272 |

***Certificate of Diagnosis***

The person below is required to undergo Classification to compete in IBD Competitions at National or International level. To assist the classificatio process a confirmation of the medical diagnosis in required.

**PERSONAL DETAILS OF BOWLS PLAYER**

FULL NAME: .............................................................................................................

ADDRESS: .............................................................................................................

 .............................................................................................................

TELEPHONE NO. ................................................................. DATE OF BIRTH: ..........................

REGION/HOME/COUNTRY: ................................................................. MALE OR FEMALE

APPLICANT’S SIGNATURE: .................................................................

**MEDICAL DETAILS**

THIS SECTION TO BE COMPLETED BY A DOCTOR OF MEDICINE ONLY

NAME OF APPLICANT: .............................................................................................................

DIAGNOSIS: .............................................................................................................

MEDICATION: .............................................................................................................

SURGERY: .............................................................................................................

ANY OTHER RELEVANT FACTORS, e.g. EPILEPSY, DIABETES, HEART DISEASE, HAEMOPHILIA:

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I HEREBY CERTIFY THAT **I HAVE FOLLOWED THIS PATIENT FOR ..... YEARS AND CERTIFY THAT THE ABOVE NAMED PATIENT HAS THE DIAGNOSIS SPECIFICED ABOVE.**

SIGNATURE OF DOCTOR: .............................................................................................................

PRINTED NAME: .............................................................................................................

ADDRESS OF DOCTOR: .............................................................................................................

**N.B. Information disclosed on this form will be dealt with according to the IPC code of ethics for classification.**