Medical Verification of Disability

To be completed by a licensed medical professional and returned to the grant applicant.

Purpose: The Neuro-Adaptive Athletes Foundation (NAAF) requires medical verification for all first-time grant applicants. This form confirms that the applicant has a permanent neurological or spinal cord condition that affects their physical abilities. It must be completed and signed by a licensed healthcare provider, submitted once, and kept on file for the lifetime of the applicant's relationship with NAAF.

ACCEPTED HEALTHCARE PROVIDERS

This form may be completed by any of the following licensed providers:

- Physician (MD or DO)
- Nurse Practitioner (NP)
- Physiatrist / PM&R Specialist
- Occupational Therapist (OT)
- Physician Assistant (PA-C)
- Neurologist
- Physical Therapist (PT)
- Spinal Cord Injury Specialist

Option A: Submit a letter or existing document on the letterhead of a treating physician or healthcare organization. The letter must identify your diagnosis and explain how your permanent physical disability affects your physical abilities and activities of daily living.

Option B: Complete this form. All fields in Sections B, C, and D must be filled out, signed, and returned to the applicant for submission. Acceptable file formats: .pdf, .jpg, .png.

SECTION A — APPLICANT AUTHORIZATION & CONSENT (Completed and Signed by Applicant Before Sending to Provider)

Athlete Full Name

Date of Birth

Sport(s) Pursued

Authorization to Disclose Health Information to NAAF

I, the undersigned applicant (or parent/legal guardian if applicant is a minor), hereby authorize my treating or evaluating healthcare provider identified in Section B of this form to disclose the following health information to the Neuro-Adaptive Athletes Foundation (NAAF):

- Nature and diagnosis of my permanent neurological or physical disability
- How my condition affects my physical abilities and activities of daily living
- Any contraindications or precautions relevant to adaptive sports participation

Purpose of Disclosure: The information disclosed will be used solely to verify eligibility for adaptive sports equipment and activity grants awarded by NAAF. It will not be used for any other purpose without my separate written consent.

Recipient of Information: Neuro-Adaptive Athletes Foundation (NAAF), 2916 Cumberland Road, Berkley, MI 48072 | contact@adaptiveathletes.org

Expiration: This authorization expires upon NAAF's final determination of my grant eligibility for the current application cycle, or two (2) years from the date signed below, whichever occurs first.

Right to Revoke: I understand that I may revoke this authorization at any time by submitting a written request to NAAF at contact@adaptiveathletes.org, except to the extent that NAAF has already taken action in reliance on this authorization. Revocation may affect my eligibility to receive a grant award.

Voluntary Consent: I understand that my authorization is voluntary. However, NAAF requires this information to process grant applications, and failure to provide authorization will result in my application being deemed incomplete.

Re-disclosure: Information disclosed pursuant to this authorization may be subject to re-disclosure by NAAF only as permitted by applicable law and NAAF's Privacy Policy. NAAF will not sell or share my health information with third parties for marketing or commercial purposes.

Applicant Signature
If applicant is a minor, parent or legal guardian must sign

Date
MM / DD / YYYY

Printed Name of Applicant or Guardian

Relationship to Applicant (if guardian)
e.g., Parent, Legal Guardian, Self

SECTION B — PROVIDER INFORMATION (Completed by Healthcare Provider)

Provider Full Name

License Type & Number

Practice / Organization Name

Address

Phone Number

Date of This Evaluation / Letter

SECTION C — DIAGNOSIS & FUNCTIONAL IMPACT

Primary Diagnosis / Condition

Condition Type (check all that apply):

- ☐ Neurological
- ☐ Neuromuscular
- ☐ Spinal Cord Injury or Disorder
- ☐ Other (describe below)

Is this condition permanent and non-reversible?

- ☐ Yes — condition is permanent
- ☐ No — condition is not permanent (applicant is not eligible)

How does this condition affect the athlete's physical abilities and activities of daily living?

Describe limitations in mobility, motor control, neuromuscular function, balance, coordination, or strength.

Are there any contraindications or precautions relevant to adaptive sports participation?

If none, write 'None.' You may note recommended adaptive modifications or equipment considerations.

SECTION D — PROVIDER CERTIFICATION & SIGNATURE

I certify that I am a licensed healthcare provider currently treating or evaluating the above-named athlete, and that the information provided in this form is accurate to the best of my knowledge. I confirm that this athlete has a permanent physical disability as described, and that this condition affects their physical abilities and activities of daily living.

Provider Signature
Provider

Date
MM / DD / YYYY

Submit as a signed PDF scan or photo to the applicant for upload. Questions? Contact us at contact@adaptiveathletes.org.