NTRP MEDICAL APPEAL FORM

THE FOLLOWING INFORMATION MUST BE COMPLETED FULLY. THIS MEDICAL APPEAL CANNOT BE CONSIDERED IF ANY PART OF THE APPEAL FORM IS INCOMPLETE.

This form must be accompanied by a current Attending Physician's Statement

(Additional medical information may be submitted but will not be accepted in lieu of an Attending Physician's Statement.)

Date:		USTA Number:	
Name:			
Address:			
City:	State:	Zip:	
Phone:	Email:	Fax:	
Date of Birth:	Age:	Gender: Select	Forehand: Select
Current NTRP Rating Level Being Appealed: Select	Date Rating Published:	NTRP Rating Level Prior to Current NTRP Rating Level: Select	
What are the dates of the next League season for which you plan to register?			
Information on Last USTA League Played:			
Date:	Location:	NTRP Rating Level: Select	Division: Select
Have you played tennis since you received your current NTRP Rating Level? Select			
If yes, describe:			
Briefly describe other USTA Leagues in which you have participated in the past, including years played:			
Have you previously filed a Medical Appeal? Select			
If yes, what year was it filed?		If yes, was it granted or denied?	
If yes, with whom was it filed?		If yes, for what injury or illness?	

Current Medical Condition(s)	
Describe the current permanently disabling injury or illness:	
Date of injury:	Date of onset of symptoms of illness:
Have you had any surgery related to this condition?	
If yes, date(s) of surgery	If yes, type(s)of surgery:
In detail, describe in your own words how this permanent injury or illness impacts your ability to play tennis:	
What treatments have you received for this condition?	
Are the treatments ongoing? Select	How long do you anticipate receiving treatments?
Has your physician ordered any kind of physical restrictions related to this medical condition?	
If yes, please describe:	
How long do you anticipate the restrictions will be in place?	
Has your physician released you to play tennis?	Date of release:
Are you currently playing tennis?	How often?
Additional Comments:	

This form, along with any and all supporting documentation and the Attending Physician's Statement, must be submitted to your Section League Coordinator or designee.

For additional Medical Appeal information, please refer to the USTA NTRP Medical Appeal Procedures – Question and Answers, available at www.usta.com/league

Signature of Player submitting this Form:

Date Signed:

By signing this form, I authorize a USTA Section Designated Medical Review Committee and the National Medical Appeal Committee to review, for the purpose of evaluating my medical appeal, any protected health information, including my medical records, that I have provided as part of this appeal.

USTA MEDICAL APPEAL - ATTENDING PHYSICIAN'S STATEMENT

Attending Physician's Statement

Patient Information			
Patient's Name:			Date of Birth:
Address:	City:	State:	Zip:
Date:	Phone:	Email:	

Your patient has submitted a medical appeal to the United States Tennis Association League. The USTA's National Medical Appeal process may grant an appeal only if a player has a **permanent**, disabling injury or illness that would impact the player's ability to play tennis at that player's current level of play.

The Medical Appeals Committee makes a concerted effort to gather accurate information in an effort to render a decision that will be fair to the player and to the player's opponents. To assist the Medical Appeals Committee in making a decision on your patient's appeal, the Committee requires an Attending Physician's Statement from you, the doctor treating this player's specific injury or illness.

Please answer the following questions on this form or provide your patient with the following information on your letterhead:

What is the patient's specific injury or illness?			
When did this injury occur or symptoms of this illness begin?			
Describe any surgery performed:		Date(s) of surgery:	
Describe other treatments received and/or receiving:			
Short Term Prognosis?		Long Term Prognosis?	
What **permanent** limitations does the patient currently have? (Please be specific about what the patient is unable to do)			
Do you expect the patient to have full recovery eventually?	Yes ☐ No ☐	Anticipated date of full recovery?	
Have you released the patient to play tennis?	Yes ☐ No ☐	If No, on what date may the patient resume playing tennis?	

Physician Information		
Name of Practice:		
Physician's Name:	Specialty:	
Address:		
City:	State:	Zip:
Phone:	Fax:	
Physician's Signature:		Date: