Appendix B: Medical Waiver Request Form

2027/2028 USA Goalball Competition Pool Selection Procedures

Purpose and Submission Requirements

- Only athletes selected to the 2026 USA Goalball National Team may request a waiver from the 2026 Open Tryout under Section 8 of the Selection Procedures.
- Use this form when a verifiable injury, illness, or medical condition prevents attendance or full participation. Extenuating circumstance requests must use Appendix C.
- Submit this completed form and all supporting medical documentation by August 31, 2026 (male athletes) or September 14, 2026 (female athletes). An emergency medical waiver arising during the Open Tryout should be submitted as soon as reasonably possible.
- A request is not complete until USABA receives the required information. Submission does not guarantee approval. Medical waiver requests are reviewed by the USA Goalball Head Team Physician(s).

Important: Keep a copy of the completed form and every attachment submitted.

1. Athlete Information

Athlete full legal name Enter full legal name	**Date of birth** MM/DD/YYYY
Email address Enter email address	**Phone number** Enter phone number
National Team Enter Men's or Women's National Team	**Athlete status** Enter adult or minor

2. Medical Waiver Request

Requested waiver type (mark one): [ ] Unable to attend Open Tryout [ ] Emergency medical waiver during Open Tryout

Open Tryout affected Enter men's or women's tryout and dates	**Date injury, illness, or condition began** MM/DD/YYYY
Date last able to participate fully in goalball MM/DD/YYYY or not applicable	**Current treatment status** Enter active treatment, rehabilitation, pending evaluation, etc.
Briefly identify the injury, illness, or medical condition Enter a concise description. Detailed medical documentation must be attached.	
Explain specifically why the condition prevents attendance or full participation in the Open Tryout Describe the functional impact and why participation is not medically appropriate or possible.	

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Medical Provider Information and Support

3. Treating Medical Provider

The provider may complete this section or submit the same information in a signed letter on professional letterhead. Supporting documentation should be sufficient to verify the medical basis for the request.

Provider name Enter provider name	**Credentials and specialty** Enter credentials and specialty
Practice or facility Enter practice or facility	**Phone number** Enter provider phone number
Email address Enter provider email address	**Fax number** Enter provider fax number or not applicable

4. Medical Support for the Waiver Request

Diagnosis or medical condition and date of diagnosis Enter diagnosis/condition and date, or reference the attached provider letter.
Current symptoms, functional limitations, and medical reason the athlete cannot attend or fully participate Describe relevant limitations and the medical basis for the requested waiver.
Current treatment and rehabilitation plan Describe treatment, rehabilitation, and expected progression.
Anticipated and reasonable return-to-play date MM/DD/YYYY
Next scheduled medical evaluation and any anticipated restrictions at return Enter follow-up date and expected restrictions, or state none.
Additional medical information relevant to this request Enter additional information or state none.

Provider certification: I certify that the information provided above or in the attached documentation is accurate to the best of my professional knowledge and supports the anticipated return-to-play date stated.

Provider signature Type or sign name	**Date** MM/DD/YYYY
Provider license number and state Enter license number and state	**Board certification, if applicable** Enter certification or not applicable

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Athlete Declaration and Submission

5. Anticipated Return and Supporting Documents

Anticipated return-to-play date stated in this request MM/DD/YYYY
Athlete plan for rehabilitation, training, and return to competitive goalball Describe the plan for following treatment, rehabilitation, and resuming competitive goalball.
List every document attached to this request List provider letters, examination notes, imaging reports, rehabilitation plans, or other supporting documents.

6. Athlete Declaration, Acknowledgments, and Limited Authorization

- I certify that the information in this request and all attachments is complete and accurate to the best of my knowledge.
- I declare my intent to return to competitive goalball on or before the anticipated return-to-play date stated in this request.
- If this waiver is approved, I agree to comply with all reporting requirements established by the USA Goalball Head Team Physician(s), including medical updates, rehabilitation progress reports, and return-to-play assessments.
- I understand that an approved waiver freezes my status as a potential Competition Pool athlete until I am medically cleared to return and evaluated by the applicable coaching staff at the first training camp after my return to play.
- I understand that approval is not automatic and that failure to return by the approved deadline, obtain an approved extension, or comply with required medical reporting may affect or end my consideration for the 2027/2028 USA Goalball Competition Pool.
- I authorize USABA and the USA Goalball Head Team Physician(s) to review the medical information I voluntarily submit with this request and to contact the medical provider identified in this form solely to evaluate the waiver request, administer required follow-up if approved, and determine return-to-play status. I understand that a medical provider may require a separate authorization before releasing additional records.

Athlete signature Type or sign name	**Date** MM/DD/YYYY
Parent or legal guardian name (required if athlete is a minor) Enter name or not applicable	**Relationship to athlete** Enter relationship
Parent or legal guardian signature Type or sign name or not applicable	**Date** MM/DD/YYYY or not applicable

7. For USABA Use Only

Date received MM/DD/YYYY	**Request status upon receipt** Complete / incomplete; list missing items
Date referred to Head Team Physician(s) MM/DD/YYYY	**Decision** Approved / denied / pending additional information
Decision rationale, conditions, required reporting schedule, and approved return-to-play deadline Enter decision details and any conditions.	
Head Team Physician signature Type or sign name	**Date** MM/DD/YYYY