

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:	Forehand:
Current NTRP Rating Level Being Appealed:	Date Rating Published:	NTRP Rating player is requesting Level:	
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:	Division:
Have you played tennis since you received your current NTRP Rating Level?			
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?			
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?	

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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?	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.