



# CYCLING FEDERATION OF INDIA

(Registered No. S/20469/89 under the Societies Registration Act - 1860)

Affiliated to Indian Olympic Association, Asian Cycling Confederation & UCI

Recognized by: Ministry of Youth Affairs & Sports, Govt. of India

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**V N Singh**

CFI/Circular/Gen./8/6/23

May 9<sup>th</sup>, 2023

## Circular of Para Selection Trials – 2023

Dear Sir/ Madam,

This is to inform you that the selection trials for the Indian Para Cycling team, for the upcoming international tournaments of track events, will be held on 28 May 2023, 10 AM onwards. The trials will take place at the IG Cycling Velodrome in New Delhi, under the association of Cycling Federation of India.

Please note the following points for those who are interested in participating in the selection trials:

1. The selection will be based purely on merit, according to the predetermined timing or speed set by CFI, and will take into consideration the past performance and international competition standards for each event and category.
2. This selection is in addition to those riders who have already secured points for qualification to world championships and paralympics.
3. Athletes wishing to compete in the selection trials and not classified before must be present for classification by UCI approved classifier, on 27 May 2023. Medical classification will be done by Ms. Asha Shaikh and Technical classification by Mr. Aditya Mehta. All athletes who are classified before, please report directly on 28 May 2023, 9am at IG Cycling Velodrome.
4. Please fill in the medical diagnostics form (MDF), related medical documents and send to [secretarygeneral@cfiindia.in](mailto:secretarygeneral@cfiindia.in), [dattu1012@gmail.com](mailto:dattu1012@gmail.com) and [ashashaikh003@gmail.com](mailto:ashashaikh003@gmail.com) by 24 May 2023.
5. Trial will only be allowed to para cyclists with competitive equipment, mandatory helmet and required essential.
6. The athletes are required to arrange their own accommodation and food.
7. The decision of the selection committee shall be final and binding to all.

Regards,

*Maninder*  
**Maninder Pal Singh,**  
Secretary General



## Medical Diagnostic Form for Athletes with a Physical Impairment

To be eligible for Para-cycling an Athlete must have an underlying medical diagnosis (Health Condition) that results in a Permanent and Eligible Impairment (Article 16.4.008 of the UCI Classification Rules and Regulations). The measurement of impairment conducted during the classification process must correspond to the diagnosis indicated below.

Completed forms and relevant Medical Diagnostic Information must be submitted. Completed forms and relevant Medical Diagnostic Information must be uploaded to the athlete's PCSAS profile upon registration of the athlete to the PCSAS no later than four (4) weeks prior to the Competition where the Athlete plans to undergo Classification. The form and the attached medical documentation may not be older than 12 months at the time of the Athlete Evaluation. The UCI holds the right to request further information, if additional information is required. The athlete will not be able to undergo Classification, until the requested information is provided.

The Athlete acknowledges and agrees that the UCI collects and processes some of his/her personal data for the purposes of and to the extent necessary in relation to the present Medical Diagnostics Form and to facilitate the Athlete's participation in UCI competitions. This personal data collected and processed include but are not limited to the Athlete's last name, first name, gender, date of birth, UCI ID, affiliated National Federation and medical information such as described below (Personal Data).

The Athlete acknowledges and agrees that the UCI may share his/her Personal Data with his/her NPC, his/her NF, UCI classifiers, the UCI Medical Director and/or the UCI Medical Commission.

Finally, the Athlete understands that he/she has a right to access and correct the Personal Data that the UCI holds about him/her under data protection law by contacting the UCI ([data.protection@uci.ch](mailto:data.protection@uci.ch)). The Athlete may withdraw his/her agreement to the UCI processing and storing his/her Personal Data at any time. The withdrawal of the Athlete's agreement to the processing and storing of his/her Personal Data may result in him/her being ineligible to participate in the sport of para-cycling. These terms must be acknowledged and signed by or on behalf of the Athlete at the bottom of this document.

**PLEASE FILL IN THE FORM ELECTRONICALLY. HARD COPIES MAILED TO THE UCI WILL NOT BE ACCEPTED.**

**Athlete Information** (to be completed by the National Federation/National Paralympic Committee)

<b>Family name:</b>	
<b>Given name/s:</b>	
<b>Gender:</b> <input type="checkbox"/> Female <input type="checkbox"/> Male	<b>Date of Birth:</b>
<b>NF (NPC):</b>	<b>UCI ID:</b>
<b>Sport Class:</b>	<b>Sport Class Status:</b>

**Medical Information** – to be completed in **English** by a registered Medical Doctor, M.D.

<b>Athlete's Medical Diagnosis (Health Condition):</b>	
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<b>Include description of body part/s affected and limitations:</b>			
<b>Primary Impairment/s arising from the Medical Diagnosis (Health Condition):</b>			
<input type="checkbox"/> Impaired muscle power	<input type="checkbox"/> Ataxia	<input type="checkbox"/> Leg length difference	
<input type="checkbox"/> Impaired passive range of movement	<input type="checkbox"/> Athetosis	<input type="checkbox"/> Limb deficiency/loss (dysmelia/ amputation)	
	<input type="checkbox"/> Hypertonia		
<b>Medical condition is:</b>	<input type="checkbox"/> Permanent	<input type="checkbox"/> Stable	<input type="checkbox"/> Progressive <input type="checkbox"/> Fluctuating
<b>Year of onset:</b>	<input type="checkbox"/> Congenital (birth)		
<b>Diagnostic Evidence to be attached:</b>			
<p>A Medical Diagnostic Report and Physical Examination results from a Health Professional qualified to examine the relevant impairment <b>MUST</b> be attached in <b>English</b> for <b>ALL</b> athletes to support the above diagnosis. Examples include:</p> <p><i>Note: The list of medical diagnosis shows examples and is not exhaustive.</i></p>			
Eligible Impairment	Name of Medical Diagnosis leading to Eligible Impairment	Documents to support the diagnosis (tick or add)	
<input type="checkbox"/> Impaired Muscle Power	<input type="checkbox"/> Spinal Cord Injury <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Spina Bifida <input type="checkbox"/> Polio Myelitis <input type="checkbox"/> Other _____	<input type="checkbox"/> Medical Report including recent ASIA scale results (both sensory and motor testing) <input type="checkbox"/> Electromyography? <input type="checkbox"/> MRI report <input type="checkbox"/> X-rays <input type="checkbox"/> Biopsy? <input type="checkbox"/> Other _____	
<input type="checkbox"/> Impaired Passive Range of Motion	<input type="checkbox"/> Arthrogryposis <input type="checkbox"/> Joint Contractures <input type="checkbox"/> Trauma <input type="checkbox"/> Other _____	<input type="checkbox"/> Medical Report (indicating cause of impairment and available range of motion) <input type="checkbox"/> X-ray (clear indication of joint abnormality) <input type="checkbox"/> Photographs <input type="checkbox"/> Other _____	
<input type="checkbox"/> Ataxia <input type="checkbox"/> Athetosis <input type="checkbox"/> Hypertonia	<input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Traumatic brain injury <input type="checkbox"/> Stroke <input type="checkbox"/> Other _____	<input type="checkbox"/> Medical Professionals report identifying if applicable Australian Spasticity Assessment Scale (ASAS) scores, reflex activity, presentation of clonus, tremor, rigidity, dystonia or dyskinesia <input type="checkbox"/> Cerebral MRI or TC scan report <input type="checkbox"/> Other _____	
<input type="checkbox"/> Leg Length Difference	<input type="checkbox"/> Trauma <input type="checkbox"/> Dysmelia <input type="checkbox"/> Other _____	<input type="checkbox"/> Medical Report <input type="checkbox"/> X-rays or <input type="checkbox"/> Photograph <input type="checkbox"/> Other _____	

<input type="checkbox"/> Limb Deficiency	<input type="checkbox"/> Dysmelia <input type="checkbox"/> Traumatic Amputation <input type="checkbox"/> Bone Cancer <input type="checkbox"/> Other _____	<input type="checkbox"/> Medical Report (specify level) <input type="checkbox"/> Radiologist Report (identify remaining bones) or <input type="checkbox"/> X-rays or <input type="checkbox"/> Photographs <input type="checkbox"/> Other _____
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UCI holds the right to request additional diagnostic evidence as per article 16.4.008 in UCI Classification Rules and Regulations, including but not limited to, report(s) from additional diagnostic testing (for example, EMG, MRI, CT, X-ray).

**Treatment History and anticipated future procedures:**

**Regular Medication – List dosage and reason:**

**Presence of additional medical conditions/diagnoses:**

- |                                                  |                                                            |                                                                            |
|--------------------------------------------------|------------------------------------------------------------|----------------------------------------------------------------------------|
| <input type="checkbox"/> Vision impairment       | <input type="checkbox"/> Impaired respiratory function     | <input type="checkbox"/> Joint Hypermobility/ instability                  |
| <input type="checkbox"/> Intellectual impairment | <input type="checkbox"/> Impaired metabolic functions      | <input type="checkbox"/> Impaired muscle endurance (e.g., Chronic fatigue) |
| <input type="checkbox"/> Hearing impairment      | <input type="checkbox"/> Impaired cardiovascular functions | <input type="checkbox"/> Other: _____                                      |
| <input type="checkbox"/> Psychological diagnoses | <input type="checkbox"/> Pain                              |                                                                            |

**Describe:**

<input type="checkbox"/> I confirm that the above information is accurate I certify that there is no contra-indication for this athlete to compete at competitive level. <b>Health Care Professional's Name:</b>	
<b>Profession/Medical Specialty:</b>	<b>Registration Number:</b>
<b>Address:</b>	
<b>City:</b>	<b>Country:</b>
<b>Phone:</b>	<b>E-mail:</b>
<b>Signature:</b>	<b>Date:</b>
<input type="checkbox"/> I confirm that the above information is accurate and I agree to the terms mentioned above. <b>Athlete Name and signature:</b>	