

पैरालंपिक कमिटी ऑफ इंडिया
PARALYMPIC COMMITTEE OF INDIA



Deemed Public Enterprise
Recognised by Govt. of India

Affiliated Member of: IPC Germany, IWAS UK, APC UAE

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President

Devendra

Padma Bhushan, Khel Ratna Awardee

Secretary General

Jayawant G Hammanawar

International Coach & Referee

Treasurer

Sunil Pradhan

International Para Athlete

Date: 15.09.2025

To
The President / Secretary,
All State/U.T. Para Sport Associations and SSCB affiliated to PCI.

Subject: XXV-National Para Swimming Championships, 2025-26.

Dear Sir / Madam,

We are glad to inform you that the Paralympic Committee of India is conducting its **XXV-National Para Swimming Championships, 2025-26** at GMC Balayogi Aquatic Complex, Gachibowli, Hyderabad from November 15-18, 2025. The Championship Package (**Attachment-1**), Medical Diagnostic Form as Annexure-1 (**Attachment-2**) and Annexures 2 to 6 (**Attachment-3**) are attached herewith, which are self-explanatory, for your kind perusal and necessary action.

PCI wishes you and your teams best of luck for the said championships!

Thanking you and looking forward to meet you and your teams there at Hyderabad.

For and on behalf of PCI

Jayawant G. H.
Secretary General

Paralympic Committee of India



Copy to:

1. The President, PCI
2. All Executive Members of PCI
3. Chairman, STC Para Swimming, PCI
4. Executive Director, Teams, SAI, New Delhi – with the request to depute one Observer to the Championship
5. NADA, New Delhi for information and necessary action.

Attachments: As mentioned above



Medical Diagnostic Form for ALL Athletes with Physical Impairment

To be eligible for World Para Swimming an athlete must have an underlying medical diagnosis (Health Condition) that results in a Permanent and Eligible Impairment (article 7 in the World Para Swimming 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 uploaded to the athlete's SDMS profile upon registration of the athlete to the SDMS. World Para Swimming holds the right to request further information, if additional information is required. The athlete will not be able to undergo classification, until such time as the requested information is provided.

Please fill in the form electronically.

Athlete Information (to be completed by the NPC)

Family name:	
Given name/s:	
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth:
NPC:	SDMS ID:

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

Athlete's Medical Diagnosis (Health Condition):				
Include description of body part/s affected and limitations:				
Primary Impairment/s arising from the Medical Diagnosis (Health Condition):				
<input type="checkbox"/> Impaired muscle power	<input type="checkbox"/> Ataxia	<input type="checkbox"/> Leg length difference		
<input type="checkbox"/> Impaired passive range of motion	<input type="checkbox"/> Athetosis	<input type="checkbox"/> Limb deficiency/loss		
	<input type="checkbox"/> Hypertonia	<input type="checkbox"/> Short stature (height: _____cm)		
Medical condition is:	<input type="checkbox"/> Permanent	<input type="checkbox"/> Stable	<input type="checkbox"/> Progressive	<input type="checkbox"/> Fluctuating

International Paralympic Committee

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Year of onset:	<input type="checkbox"/> Congenital (birth)
Diagnostic Evidence to be attached:	
Evidence to support the above diagnosis MUST be attached in English for ALL athletes:	
<input type="checkbox"/> Medical Diagnostic Report and Physical Examination results (for example ASIA scale for Athletes with Spinal Cord Injury, Ashworth Scale for Athletes with Cerebral Palsy, X-rays for Athletes with dysmelia, photo for Athletes with amputation)	
World Para Swimming holds the right to request additional diagnostic evidence as per article 7.5 and 7.6 in World Para Swimming Classification Rules and Regulations, including but not limited to:	
<input type="checkbox"/> Report(s) from additional diagnostic testing (for example, EMG, MRI, CT, X-ray)	
Treatment History:	
Regular Medication – List dosage and reason:	
Presence of additional medical conditions/diagnoses:	
<input type="checkbox"/> Vision impairment <input type="checkbox"/> Intellectual impairment <input type="checkbox"/> Hearing impairment <input type="checkbox"/> Psychological diagnoses	<input type="checkbox"/> Impaired respiratory function <input type="checkbox"/> Impaired metabolic functions <input type="checkbox"/> Impaired cardiovascular functions <input type="checkbox"/> Pain
<input type="checkbox"/> Joint Hypermobility/ instability <input type="checkbox"/> Impaired muscle endurance (e.g., Chronic fatigue) <input type="checkbox"/> Other: _____	
Describe:	

<input type="checkbox"/> I confirm that the above information is accurate	
Doctors Name:	
Medical Specialty:	Registration Number:
Address:	
City:	Country:
Phone:	E-mail:
Signature:	Date: