**WT Medical Suspension Form for Concussion/Knockdown**

* ***Indication: Any athlete with a diagnosis of concussion or head trauma which is made by WT commissioned doctor or OMD during the competition***

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| --- | --- | --- | --- |
| **Date** |  | **Time** |  |
| **Competition**  |  |
| **Full Name of the Injured Athlete**  |  |
| **Nationality** |  | **WT GAL No.** |  |
| **Weight Category** |  | **Sex** |  |
| **Nature of Head trauma** |  |
| **Treatment** |  |

**※ Please send (1) Medical Certificate AND (2) SCAT 5 form for this certificate) to the WT Sports Department (***sport@worldtaekwondo.org**)* **and WT Medical Chairman (***dhjeong15@gmail.com*)**to be released from the suspension and resume the competition**.

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| --- |
|  Your athlete Mr./Ms. had significant head injury (or knockdown by h) by the opponent during the round of . In conformity with the WT Medical Code, any athlete who cannot continue not continue the match as a result of either (1) loss of consciousness more than 10 seconds by knockdown, (2) Failure to fully recover from head trauma and resume the match within one minute of medical evaluation on the mat or (3) signs or symptoms that suggests concussion by neurologic examination including SCAT5 will get mandatory medical suspension. Therefore, per the WT Medical Code, he/she shall have [30 (senior)/ 40 (junior)/50 (cadet)] days of medical suspension from today, and may not participate in any competition during the suspension period.  To resume the competition, the athlete must have a formal follow-up evaluation for neurologic exam and concussion evaluation, receive a medical clearance letter by the medical doctor (either neurologist or certified concussion specialist) which must be sent to WT Sport Department (sport@worldtaekwondo.org) and WT Medical Chairman (dhjeong15@gmail.com). WT Medical Chairman will review the letter and make a decision on approval for clearance, which will be informed by e-mail. |
|  Official Medical Director / WT Commissioned Doctor* Name:
* Signature:
* Date:
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**[Sample Letter of the medical clearance for return-to-competition]**

I, the undersigned medical doctor specialized in Neurology (or Certified Concussion Specialist) certify that I have examined the

(Nationality) athlete, Mr/Ms . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .who had a (head injury or concussion) on (DD/MM/YY) at (name of competition) by (explain the mechanism of injury, such as kicking, fall on head, etc).

Comprehensive physical examination and neurologic examination was performed today.

Currently, he/she does not present any neurological abnormality nor signs/symptoms suggesting concussion. Therefore, I certify that the athlete has been fully recovered from concussion (or head trauma) and the athlete may return to competition after the mandatory medical suspension period is completed.

Date of visit

Name of the medical doctor

Signature

Speciality of the medical doctor (must be neurologist or concussion specialist)

Address of the hospital (or office) of the certifying medical doctor