

## Appendix One – Athletes with Physical Impairment

### I. Sport Classes for Physical Impairment

*Sport Climbing offers competitions for Athletes with physical impairments covering all 8 of the IPC’s eligible physical impairment types over 7 sport classes for each gender. The following are general definitions: see individual classification criteria for more details.*

1. AU1: Severe Upper Limb impairment - One upper limb is absent or has severely limited functional use for climbing.
2. AU2: Moderate Upper Limb impairment - One upper limb has reduced function
3. AL1: Bilateral Lower Limb impairment - Significantly reduced functional use for climbing or absence of bilateral lower limbs.
4. AL2: Unilateral Lower Limb impairment or leg length difference - Impairment in a single lower limb.
5. RP1: “Range, Power” severe impairment, inclusive of other impairment types - Impairment across all eligible impairment types with severe impairment to function affecting at least 2 limbs.
6. RP2: “Range, Power” moderate impairment, inclusive of other impairment types - Impairment across all eligible impairment types with moderate impairment to function affecting the trunk and/or limbs.
7. RP3: “Range, Power” mild impairment, inclusive of other impairment types - Impairment across all eligible impairment types with mild impairment to function affecting the trunk and/or limbs.

### II. Eligibility

An athlete is eligible to compete in Paraclimbing if they meet both below criteria:

1. The athlete demonstrates one of the eligible impairments defined in section 3 and has submitted a completed Medical Diagnostics Form signed by a physician.
2. The athletes Eligible Impairment meets the minimum Impairment criteria defined in section 4.

### III. Eligible Impairment Types

The following impairments are Eligible Impairments for Paraclimbing.

Eligible Impairment	Examples of Health Conditions
<p><b>Impaired Muscle Power</b></p> <p>Athletes with Impaired Muscle Power have a Health Condition that either reduces or eliminates their ability to voluntarily contract their muscles in order to move or to generate force.</p>	<p>Examples of an Underlying Health Condition that can lead to Impaired Muscle Power include spinal cord injury (complete or incomplete, tetra- or paraplegia or paraparesis), muscular dystrophy, post-polio syndrome and spina bifida.</p>
<p><b>Limb Deficiency</b></p> <p>Athletes with Limb Deficiency have total or partial absence of bones or joints as a consequence of trauma.</p>	<p>Examples of an Underlying Health Condition that can lead to Limb Deficiency include: traumatic amputation, illness (for example amputation due to bone cancer) or congenital limb deficiency (for example dysmelia).</p>
<p><b>Leg Length Difference</b></p> <p>Athletes with Leg Length Difference have a difference in the length of their legs.</p>	<p>Examples of an Underlying Health Condition that can lead to Leg Length Difference include: dysmelia and congenital or traumatic disturbance of limb growth.</p>

<p><b>Short Stature</b></p> <p>Athletes with Short Stature will have a reduced length in the bones of the upper limbs, lower limbs and/or trunk.</p>	<p>Examples of an Underlying Health Condition that can lead to Short Stature include achondroplasia, growth hormone dysfunction, and osteogenesis imperfecta.</p>
<p><b>Hypertonia</b></p> <p>Athletes with hypertonia have an increase in muscle tension and a reduced ability of a muscle to stretch caused by damage to the central nervous system.</p>	<p>Examples of an Underlying Health Condition that can lead to Hypertonia include cerebral palsy, traumatic brain injury, stroke and multiple sclerosis.</p>
<p><b>Ataxia</b></p> <p>Athletes with Ataxia have uncoordinated movements caused by damage to the central nervous system.</p>	<p>Examples of an Underlying Health Condition that can lead to Ataxia include cerebral palsy, traumatic brain injury, stroke and multiple sclerosis.</p>
<p><b>Athetosis</b></p> <p>Athletes with Athetosis have continual slow involuntary movements.</p>	<p>Examples of an Underlying Health Condition that can lead to Athetosis include cerebral palsy, traumatic brain injury and stroke.</p>
<p><b>Impaired Passive Range of Movement</b></p> <p>Athletes with Impaired Passive Range of Movement have a restriction or a lack of passive movement in one or more joints.</p>	<p>Examples of an Underlying Health Condition that can lead to Impaired Passive Range of Movement include arthrogyposis and contracture resulting from chronic joint immobilisation or trauma affecting a joint.</p>

**IV. Minimum Impairment Criteria**

To be eligible to compete in Paraclimbing, the athlete’s eligible impairment must meet one (1) or more of the following minimum impairment criteria.

**1. Impaired Muscle Power**

Impaired muscle power in one (1) or more limbs effecting at least one (1) or more planes of movement excluding toe flexors and extensors with at least one muscle group scoring 3 or less. Maximum cumulative MRC score of 175/180.

**2. Limb Deficiency**

Upper Limb: Unilateral amputation or deficiency of 6 DIP or PIP joints in one or across both hands.  
 Lower Limb: Unilateral amputation or deficiency through the distal limb with the absence of a functional ankle joint.

**3. Leg Length Difference**

Leg length difference as a minimum of 20% reduction in limb length compared with the longer limb. Measurements are to be taken from the anterior superior iliac spine to the tip of the ipsilateral medial malleolus.

**4. Short Stature**

Standing height must be less than or equal to 140cm.

5. Hypertonia

Hypertonia must be present at least one (1) long bone joint in at least one (1) limb with a minimum Modified Ashworth Scale score of two (2). Where dystonia is present variability in Modified Ashworth Scale score is acceptable. Hypertonia must impact on climbing ability. A functional test battery will be performed to assess the impact of hypertonia on climbing ability.

6. Ataxia

Athletes must demonstrate an observable involvement in one (1) or more limbs. Ataxia must impact on climbing ability. A functional test battery will be performed to assess the impact of ataxia on climbing ability.

7. Athetosis

Athletes must demonstrate an observable involvement in one (1) or more limbs. Athetosis must impact on climbing ability. A functional test battery will be performed to assess the impact of athetosis on climbing ability.

8. Impaired Passive Range of Movement

Athletes must demonstrate Impaired Passive Range of Movement in at least (1) one joint in at least one (1) limb. This impairment must be significant enough to score them a score of six (6) using the weighted value of ROM impairments as it applies to climbing performance.

**V. Assessment Methodology**

*Athletes with eligible impairments will be assessed using the following methodology.*

Athletes will be asked:

- When they started climbing
- How frequently they train for climbing
- If they cross train in other sports
- How long they have been competing for
- If an impairment is acquired, whether they commenced climbing before or after the injury

1. Impaired Muscle Power

1.1. All affected muscle groups shall be identified on the submitted Medical Diagnostics Form with supporting and relevant medical documentation. An MRC scale is used to assess muscle power in all key muscle groups. The following table converts MRC scale into scores used for the purpose of classification.

MRC Scale	Classification points
1 or 2	0
3	3
4	4
5	5

1.2. The following muscle groups will be evaluated for the purpose of classification

	Upper limb (10)	Total / 100
1	Finger flexion	Score / 5
2	Finger abduction	Score / 5
3	Thumb flexion/adduction combined	Score / 5

4	Wrist flexion	Score / 5
5	Wrist extension	Score / 5
6	Elbow flexion	Score / 5
7	Elbow extension	Score / 5
8	Shoulder flexion	Score / 5
9	Shoulder abduction	Score / 5
10	Shoulder adduction	Score / 5

	<b>Lower limb (7)</b>	<b>Total / 70</b>
1	Ankle plantar flexors	Score / 5
2	Knee extensors	Score / 5
3	Knee flexors	Score / 5
4	Hip adductors	Score / 5
5	Hip abductors	Score / 5
6	Hip flexors including compensation from sartorius	Score / 5
7	Hip extensors	Score / 5

	<b>Trunk (2)</b>	<b>Total / 10</b>
1	Abdominal flexors	Score / 5
2	Back extensors	Score / 5

<b>Total combined score</b>	<b>Score / 180</b>
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2. Limb Deficiency

2.1. Affected limbs and joints are identified on the submitted medical form

2.2. Limb observation accompanied by medical letter. Consideration of prosthetic use is done at this time but will not affect an athlete's classification. Where delineation of limb deficiency is unclear an X-Ray should be provided for review.

3. Leg Length Difference

3.1. Affected limbs should be identified on the submitted medical form

3.2. Limb length measurements are to be taken from the anterior superior iliac spine to the tip of the ipsilateral medial malleolus. Measurements are to be taken twice and the mean of these two measurements used.

4. Short Statue

4.1. Standing height should be identified on the submitted medical form with supporting medical documentation related to the diagnosis. Standing height must be measured barefoot with feet flat.

5. Hypertonia

5.1. Hypertonia, including spasticity and dystonia, in all affected joints is identified on the submitted medical form with supporting medical documentation related to the diagnosis.

5.2. Athletes will be asked to perform a functional test designed to highlight the impact of hypertonicity impairment on climbing. The outcome of this test will be used alongside the spasticity assessment to determine the appropriate sport class. The test battery involves a series of movement tasks in which a climber is scored out of 2 for each task.

5.3. Key muscle groups assessed for the purpose of classification are:

**Upper limb**

- Finger flexors (Flexor digitorum longus or Flexor digitorum superficialis)\*
- Wrist flexors (Flexor carpi ulnaris or flexor carpi radialis)\*
- Pronators (Pronator teres or Pronator Quadratus)\*
- Elbow Flexors (Biceps, Brachialis or Brachioradialis)
- Elbow extensors (Triceps)
- Shoulder Adductors (Pectoralis Major/Minor, Latissimus Dorsi, or Subscapularis)

**Lower limb**

- Dorsiflexors (Tibialis anterior or peroneal)
- Foot invertors (Tibialis posterior)
- Plantar flexors (Gastrocnemius or soleus)
- Knee flexors (Hamstrings)
- Knee Extensors (Quadriceps)
- Hip adductors
- Hip flexors (Iliopsoas, sartorius)

\* distal upper limb muscle groups

Assessment of clonus and/ or tendon reflexes may also be used to confirm the underlying health condition.

6. Ataxia

6.1. Body area(s) affected by ataxia should be identified on the submitted medical form with supporting medical documentation related to the diagnosis.

6.2. Athletes will be asked to perform a functional test designed to highlight the impact of ataxia impairment on climbing. The test battery involves a series of movement tasks in which a climber is scored out of 2 for each task.

7. Athetosis

7.1. Body area(s) affected by athetosis should be identified on the submitted medical form with supporting medical documentation related to the diagnosis.

7.2. Athletes will be asked to perform a functional test designed to highlight the impact of athetosis impairment on climbing. The test battery involves a series of movement tasks in which a climber is scored out of 2 for each task.

8. Impaired Passive Range of Movement

8.1. Affected limbs and joints are identified on the submitted medical form with supporting medical documentation related to the diagnosis.

8.1.1. Upper limb and lower limb joint range of motion will be measured using inclinometers and goniometers. Trunk measurements will be taken using surface anatomy landmarks and a tape measure, some trunk measurements may also use an inclinometer.

8.1.2. ROM measurements are then weighted, and these values added to determine a ROM score. The weighting of ROM limitations for each joint is described as follows:

Neck Range in Sagittal Plane (Flex/Ext)	Score
11°-30° of movement	1
< 10° of movement	2
Fixed position	3

Neck rotation	Score
Cannot achieve neutral (midline)	1

Shoulder flexion	Score
131° - 150°	1
91° - 130°	2
< 90°	4
Fixed Shoulder (flexion or abduction)	12

Shoulder extension	Score
Cannot achieve neutral (arm by side)	2

Shoulder abduction	Score
131° - 150°	1
91° - 130°	2
< 90°	4

Shoulder horizontal adduction	Score
< 45°	1
Cannot achieve neutral (shoulder flexion at 90°)	3

Shoulder rotation range Measured in 90 degrees of abduction, scapula stabilized	Score
46° - 90° of movement	1
< 45° of movement	2
Fixed	3

Elbow flexion	Score
61° - 90°	2
< 60°	3
Fixed Elbow (flexion or extension)	5

Elbow extension	Score
-45° to -90°	3
> -90°	4

Supination (neutral = thumb up)	Score
31° - 60°	1
0° - 30°	2
< 0°	3

Pronation	Score
31° - 60°	2
0° - 30°	3
< 0°	4

Wrist extension (with finger flexion)	Score
0° - 20°	1
< 0°	2
Fixed Wrist (flexion or extension)	4

Wrist Flexion (with finger flexion)	Score
0° - 20°	1
< 0°	2

Thumb opposition / adduction	Score
Cannot achieve thumb to base of 4 <sup>th</sup> finger	1
Cannot achieve thumb to base of 2 <sup>nd</sup> finger	2
Fixed	3

MCP (one score per hand, must affect at least 2 MCP joints)	Score
Extension -45° to -90°	1
> -90° or fixed (in any position)	3

Finger flexion (PIP and DIP combined, at least 2 fingers; one score per hand)	Score
-45° to -90°	2
-45° to 0°	3
Fixed Fingers (flexion or extension)	5

Finger extension (PIP and DIP combined, at least 2 fingers; one score per hand)	Score
0° to -45°	2
-45° to -90°	3

Combined Thoracolumbar extension (assessed in sitting)	Score
0° to -10°	1
-10° to -30°	3
> -30°	4

Combined Thoracolumbar rotation range available (assessed in sitting)	Score
10° - 40°	2
< 10°	4

Hip flexion	Score
61° - 90°	3
31° - 60°	4
< 30°	5
Fixed (flexion or extension)	8

Hip extension	Score
-20° to -45°	3
> -45°	4

Combined Hip rotation range	Score
21° - 45°	2
1° - 20°	3
Fixed	4

Hip abduction	Score
< 20°	3
Can only achieve 0°	4
-1° to -30°	5
Fixed (abduction or adduction)	5

Hip adduction	Score
Cannot achieve neutral (0°) - hip in abduction	1

Knee extension	Score
-10° to -30°	3
-31° to -45°	4
> -45°	5

Knee flexion	Score
46° - 90°	2
15° - 45°	3
0° - 15°	4
Knee fixed (flexion or extension)	8

Ankle dorsiflexion (ankle neutral = 0 DF or PF) Measured in knee flexion	Score
0° to -15° DF	1
> -15° DF	2

Ankle plantarflexion	Score
< 15° PF	1
Fixed ankle at any position 10° DF - 15° PF	2
Fixed ankle between 15° - 30° PF	3
Fixed ankle in > 10° DF or > 30° PF	4

Ankle inversion / eversion	Score
Fixed in subtalar neutral position	1
Unable to achieve subtalar neutral position (including fixed)	2



## VI. Assessment Criteria for the Allocation of a Sport Class and the Designation of Sport Class Status

Eligible impairments will be assessed according to impairment distribution and severity and allocated to a sport class.

### 1. Sport classes by impairment

#### 1.1. Impaired muscle power

- a. AU1 athletes must have a muscle power deficit of at least 35 points all retracted from the score of a single upper limb.
- b. AU2 athletes must have a muscle power deficit of at least 20 points all retracted from the score of a single upper limb
- c. AL1 athletes must have at least 60 points retracted from the score of their lower limbs
- d. RP1 athletes must have a muscle power deficit of at least 40 points with muscle power impairment distributed across all 4 limbs.
- e. RP2 athletes must have a muscle power deficit of at least 20 points affecting at least 2 limbs.
- f. RP3 athletes must have a muscle power deficit of at least 5 points regardless of limb distribution with at least one muscle group scoring 3 or less.

#### 1.2. Limb Deficiency

- a. AU1 climbers with a minimum deficiency of loss of a limb through the elbow joint with no residual limb below this point
- b. AU2 athletes have a minimum deficiency of limb from the forearm
- c. AL1 athletes have a minimum deficiency of loss of limb through both knee joints
- d. AL2 athletes have a minimum deficiency of loss of limb through the distal limb with the absence of a functional ankle joint. RP3 athletes have a minimum deficiency of 6 DIP or PIP joints in one or across both of their hands

#### 1.3. Leg Length Difference

AL2 athletes may have a Leg length difference as a minimum of 20% reduction in limb length compared with the longer limb.

#### 1.4. Short Stature

RP3 athletes must have a standing height of less than or equal to 140 cm.

#### 1.5. Hypertonia

- a. AU1 athletes have hypertonia resulting in at least 1 arm which is entirely unable to function at the elbow and distal for the purpose of climbing.
- b. AU2 athletes have hypertonia with a minimum MAS score of two (2) affecting all key groups in their distal upper limb.
- c. RP1 athletes must have hypertonia present in minimum of 4 key muscles groups in at least 2 limbs with a minimum MAS score of two (2). They must also have a deficit of at least 30 points on the functional test battery.
- d. RP2 athletes must have hypertonia present in a minimum of 2 keys muscle groups across 2 limbs with a minimum MAS score of two (2). They must also have a deficit of at least 20 points on the functional test battery.
- e. RP3 athletes must have hypertonia present in a key muscle group in at least one (1) limb with a minimum MAS score of two (2). They must also have a deficit of at least 8 points on the functional test battery.

Where dystonia is present variability in Modified Ashworth Scale score is acceptable.

#### 1.6. Ataxia

- a. RP1 Athletes must demonstrate an observable involvement in 4 limbs. They must also have a deficit of at least 30 points on the functional test battery.
- b. RP2 Athletes must demonstrate an observable involvement in 2 limbs. They must also have a deficit of at least 20 points on the functional test battery.
- c. RP3 Athletes must demonstrate an observable involvement in 1 limb. They must also have a deficit of at least 8 points on the functional test battery.

#### 1.7. Athetosis

- a. RP1 Athletes must demonstrate an observable involvement in 4 limbs. They must also have a deficit of at least 30 points on the functional test battery.
- b. RP2 Athletes must demonstrate an observable involvement in two limbs. They must also have a deficit of at least 20 points on the functional test battery.
- c. RP3 Athletes must demonstrate an observable involvement in one limb. They must also have a deficit of at least 8 points on their functional test battery.

#### 1.8. Impaired Passive Range of Motion

- a. RP1 athletes must have a ROM score of 36 or more with involvement of 4 limbs
- b. RP2 athletes must have a ROM score of 18 or more with involvement of 2 limbs
- c. RP3 athletes must have a ROM score of 6 or more regardless of limb distribution

### 2. Sport classes defined across impairment types

#### 2.1. AU1: Severe Upper limb impairment

- a. Athletes must have a muscle power deficit of at least 35 points all retracted from the score of a single upper limb, OR
- b. Athletes with a minimum deficiency of loss of a limb through the elbow joint with no residual limb below this point, OR
- c. Athletes have hypertonia resulting in at least 1 arm which is entirely unable to function at the elbow and distal for the purpose of climbing.

#### 2.2. AU2: Moderate Upper limb impairment

- a. Athletes must have a muscle power deficit of at least 20 points all retracted from the score of a single upper limb, OR
- b. Athletes have a minimum deficiency of limb from the forearm, OR
- c. Athletes have hypertonia with a minimum MAS score of two (2) affecting all key muscle groups in their distal upper limb.

#### 2.3. AL1: Bilateral Lower limb impairment

- a. Athletes must have a muscle power deficit of at least 60 points all retracted from the score of their lower limbs, OR
- b. Athletes have a minimum deficiency of loss of limb through both knee joints

#### 2.4. AL2: Unilateral Lower limb impairment or leg length difference

- a. Athletes have a minimum deficiency of loss of limb through the distal limb with absence of a functional ankle joint OR
- b. Athletes may have a Leg length difference as a minimum of 20% reduction in limb length compared with the longer limb

2.5. RP1: “Range, Power” severe impairment, inclusive of other impairment types

- a. Athletes must have a total muscle power score of less than 140 affecting all 4 limbs, OR
- b. Athletes must have hypertonia present in minimum of 4 key muscles groups in at least 2 limbs with a minimum MAS of 2 and have a deficit of at least 30 points on the functional test battery, OR
- c. Athletes must demonstrate an observable involvement of ataxia in 4 limbs and have a deficit of at least 30 points on the functional test battery, OR
- d. Athletes must demonstrate an observable involvement of athetosis in 4 limbs and have a deficit of at least 30 points on the functional test battery, OR
- e. Athletes must have a ROM score of 36 or more with involvement of 4 limbs.

2.6. RP2: “Range, Power” moderate impairment, inclusive of other impairment types

- a. Athletes must have a muscle power score of 141-160 affecting at least 2 limbs, OR
- b. Athletes must have hypertonia present in a minimum of 2 keys muscle groups across 2 limbs with a MAS score of 2 and have a deficit of at least 20 points on the functional test battery OR
- c. Athletes must demonstrate an observable involvement of Ataxia in 2 limbs and have a deficit of at least 20 points on the functional test battery OR
- d. Athletes must demonstrate an observable involvement of Athetosis in two limbs and have a deficit of at least 20 points on the functional test battery, OR
- e. Athletes must have a ROM score of 18 or more with involvement of at least 2 limbs

2.7. RP3: “Range, Power” mild impairment, inclusive of other impairment types

- a. Athletes must have a muscle power score of 161-175 regardless of limb distribution with at least one muscle group scoring 3 or less. OR
- b. Athletes have a minimum limb deficiency of 6 DIP or PIP joints in one or across both of their hands, OR
- c. Athletes must have a standing height of less than or equal to 140cm.
- d. Athletes must have hypertonia present in a key muscle group in at least 1 limb with a minimum MAS score of 2 and have a deficit of at least 8 points on the functional test battery, OR
- e. Athletes must demonstrate an observable involvement of Ataxia in 1 limb and have a deficit of at least 8 points on the functional test battery, OR
- f. Athletes must demonstrate an observable involvement of Athetosis in 1 limb and have a deficit of at least 8 points on the functional test battery, OR
- g. Athletes must have a ROM score of 6 or more regardless of limb distribution



## VII. Sport specific test

1. The sport specific test will be carried out on a climbing wall. The climbing moves described down below will be demonstrated by the athlete on a testing route while the Classifiers observe the athlete's performance.
2. The climb will not be a defined route, but the route used should include the following:
  - a. Consecutive pinch holds
  - b. A segment that is not overhung
  - c. A movement onto an overhung surface
  - b. 4-5 moves on an overhung surface
  - c. A movement that forces both feet to leave the wall
  - d. 4-5 holds that an athlete is required to crimp, these holds should be at different angles.
  - e. 2-3 small foot holds
  - f. A movement that forces the athlete to cross their arms over
  - g. A movement that forces the athlete to demonstrate use of compression
  - h. A forced dynamic movement
3. The following combined movements to be observed during classification
  - a. Shoulder Flexion / ext rotation / abduction
  - b. Hip flexion / ext rotation / abduction
  - c. Hip flexion with and without knee extension
4. A climber should be observed how he approaches to route including observation before climbing on the route.
5. The sport specific test shall be carried out below the athlete's performance limit however the structure of the climb is designed to that climbers may be forced into a move that is incompatible with their ability based on their impairment.
6. The routesetting team shall prepare one or two routes or identify one or two established routes for the sport specific test. This may be on the warm-up wall or a full height climbing wall near the competition wall. Competition routes may not be used for this test.

## Appendix Two - Athletes with Vision Impairment

### I. Eligible Impairment Types

Eligible Impairment	Examples of Health Conditions
<p><b>Vision Impairment</b> Athletes with Vision Impairment have reduced or no vision caused by damage to the eye structure, optical nerves or optical pathways, or visual cortex of the brain.</p>	<p>Examples of an Underlying Health Condition that can lead to Vision Impairment include retinitis pigmentosa and diabetic retinopathy.</p>

### II. Minimum Impairment Criteria

Minimum Impairment Criteria for Athletes with a Vision Impairment have been set based on the Athlete's corrected vision. (The difference in approach for Athletes with Vision Impairment must be seen within the historical context of Classification for these Athletes, which is an assessment with 'best correction' as used in the context of medical diagnostics for visual acuity.)

1. To be eligible to compete in Sport Classes B1-B3 in IFSC Paraclimbing, the Athlete must meet both of the criteria below:
  - 1.1. The Athlete must have at least one of the following Impairments:
    - a. Impairment of the eye structure;
    - b. Impairment of the optical nerve/optic pathways;
    - c. Impairment of the visual cortex.
  - 1.2. The Athlete's Vision Impairment must result in a visual acuity of less than or equal to LogMAR 1.0 or a visual field restricted to less than 40 degrees diameter.
2. It is the responsibility of the Athlete and National Federation to provide sufficient evidence of the Vision Impairment. This must be done by way of submitting medical diagnostic information completed by an ophthalmologist as described in Article 7.5 of these Rules.
3. The medical diagnostic information must comprise the completed Medical Diagnostics Form (available on the IFSC Website) and additional medical documentation as indicated on the Medical Diagnostics Form. Failure to present with complete medical diagnostic information may lead to Athlete Evaluation being suspended in accordance with Article 10 of these Rules.
4. Medical Diagnostic Information must be submitted in English and may not be older than 12 months prior to the date of Evaluation Session.

### III. Assessment Methodology

1. All Athlete Evaluation and Sport Class allocation must be based on the assessment of visual acuity in the eye with better visual acuity when wearing the best optical correction.
2. Depending on an Athlete's visual acuity, visual acuity is tested using the LogMAR chart for distance visual acuity testing with Illiterate „E“ and/or the Berkeley Rudimentary Vision Test.
3. Athletes who compete using any corrective devices (e. g. glasses, lenses) must attend classification with these devices and their prescription.
4. An Athlete found to be using corrective devices during Competition that were not declared during Evaluation Session may be subject to further investigation of Intentional Misrepresentation (see Article 30).
5. Athletes must declare any change in their optical correction to the IFSC before any Competition. If the Athlete has a Sport Class Status Review with Fixed Review Date or Confirmed, the Athlete's Sport Class Status will be changed to Review. The



Athlete will then undergo Athlete Evaluation prior to the next Competition under the provisions of these Rules. Failure to do so may result in an investigation of Intentional Misrepresentation (see Article 30).

6. Any Athlete Support Personnel accompanying the Athlete during the Evaluation Session must remain out of sight of the visual acuity charts during assessment.
7. Under the current provisions set out in this Appendix, Observation in Competition does not apply to Athletes with Vision Impairment.
8. The IFSC will inform the local organising committee of the equipment and room requirements for the assessment of Athletes with Vision Impairment after the Classification Panels have been appointed. It is the local organising committee responsibility to provide all equipment required by the IFSC.
9. Failure to provide all equipment required by the IFSC may result in the classification decisions not being accepted by the IFSC.

#### **IV. Assessment Criteria for the Allocation of a Sport Class and the Designation of Sport Class Status**

1. Sport Class B1
  - 1.1. Visual acuity is poorer than LogMAR 2. 60.
2. Sport Class B2
  - 2.1. Visual acuity ranges from LogMAR 1. 50 to 2. 60 (inclusive), and/or
  - 2.2. the visual field is constricted to a radius of less than 10 degrees diameter.
3. Sport Class B3
  - 3.1. Visual acuity ranges from LogMAR 1. 40 to 1 (inclusive), and/or
  - 3.2. The visual field is constricted to a radius of less than 40 degrees diameter.

### Appendix Three - Observation in Competition procedure

The classification panel may observe the whole event with all relevant components such as:

- a. Warm up area
- b. Isolation
- c. Qualification(s)
- d. Final round(s).

After finishing all qualification rounds, the classification panel will finalise decisions on the Sport Class Status.

The classification panel may use video footage or other records to assist in observation in competition.

If the classification panel has evidence that the athlete's behaviour and/or performance in competition fits to the medical assessment results and assigned sport class, the Sport Class Status C (confirmed) or FRD (fixed review date) in case of expected changing conditions will be granted.

If the classification panel has evidence that the athlete's behaviour and/or performance in competition does not fit to the medical assessment results and assigned sport class, the classification panel may assign the status R (Review) and the athlete will undergo a medical assessment at the next possible occasion. Without this medical reassessment, the athlete may not compete in any further IFSC event.

If an athlete would benefit from a wrong Sport Class designation, the classification panel may decide to designate the Sport Class Status Classification Not Completed (CNC) in accordance with Article 10 of these Classification Rules. The classification panel may further decide to start investigations in respect of possible Intentional Misrepresentation in accordance with Article 32 of these Rules. An Athlete with the Status CNC is not allowed to compete in finals and no results are granted for this competition. The athlete will undergo a medical assessment at the next possible occasion. Without this medical reassessment, the athlete may not compete in any further IFSC event.

All qualification results are published together with the Classification panel decisions on the Sport Class Status.

## Appendix Four - Non-Eligible Impairment Types

### 1. Non-Eligible Impairment Types for all Athletes

Examples of Non-Eligible Impairments include, but are not limited to the following:

- a. Pain;
- b. Intellectual Impairment;
- c. Hearing impairment;
- d. Low muscle tone;
- e. Hypermobility of joints;
- f. Joint instability, such as unstable shoulder joint, recurrent dislocation of a joint;
- g. Impaired muscle endurance;
- h. Impaired motor reflex functions;
- i. Impaired cardiovascular functions;
- j. Impaired respiratory functions;
- k. Impairment metabolic functions; and
- l. Tics and mannerisms, stereotypies and motor perseveration.

### 2. Health Conditions that are not Underlying Health Conditions for all Athletes

A number of Health Conditions do not lead to an Eligible Impairment and are not Underlying Health Conditions. An Athlete who has a Health Condition (including, but not limited to, one of the Health Conditions listed in the above Appendixes Appendix One and/or Appendix Two) but who does not have an Underlying Health Condition will not be eligible to compete in IFSC Paraclimbing.

Health Conditions that primarily cause pain; primarily cause fatigue; primarily cause joint hypermobility or hypotonia; or are primarily psychological or psychosomatic in nature do not lead to an Eligible Impairment.

Examples of Health Conditions that primarily cause pain include myofascial pain-dysfunction syndrome, fibromyalgia, or complex regional pain syndrome.

An example of a Health Condition that primarily causes fatigue is chronic fatigue syndrome.

An example of a Health Condition that primarily causes hypermobility or hypotonia is Ehlers-Danlos syndrome.

Examples of Health Conditions that are primarily psychological or psychosomatic in nature include conversion disorders or post-traumatic stress disorder.