

INTERNATIONAL PARALYMPIC EQUESTRIAN COMMITTEE

I.P.E.C.

**I.P.C. Sports Assembly Executive
Committee**



CLASSIFICATION MANUAL **for** Equestrian Competition for Riders with Disabilities

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CLASSIFICATION FOR INTERNATIONAL EQUESTRIAN COMPETITION

PROTOCOL

Classification is an attempt to ensure fair equestrian competition. All disabled riders who intend to enter national or international competitions must produce a certificate that states their full medical diagnosis. The impairment is assessed and the resulting **functional profile** is combined with other profiles that should have similar ability when mounted. There are four **Grades of competition**. Grade I is for the more severely impaired riders, Grade IV is for the least severely impaired riders. The competition within each Grade can then be judged on the functional skill of the rider regardless of disability.

"impairments are problems in body function or structure such as a significant deviation or loss"
(W.H.O. 2000)

Impairments may be broadly classified as locomotor, sensory, cerebral, or other impairments. A system for the classification of impairment should be simple to use, flexible enough to apply to all impairments, sport specific, and it should be acceptable to the rider.

Personnel: Roles and Responsibilities

Classification for national competition must be carried out by a national I.P.E.C. classifier. If no national classifier is available, a national I.P.E.C. classification adviser can classify with a medically qualified physiotherapist or doctor. Classification for Profile 36 and 37 must be carried out by an ophthalmologist or optical doctor, (see Appendix 2) and for Profile 39 by a psychologist (see Appendix 1).

Classification for international competition must be carried out by two Internationally accredited Paralympic Equestrian Committee classifiers. The classification may be done by the two classifiers together or separately, but one classifier must be from a different nation to the rider. It is helpful to have an approved Technical Delegate in attendance or available to provide expertise regarding technical ability.

Physiotherapists and medical doctors approved by I.P.E.C. must be qualified in handling competitors with a disability, and have a clear understanding of the profile system of classification. In addition, the role of the medical doctor includes overseeing the safety of the rider, and advising on any diagnostic queries. The medical doctor has the power to prevent a rider competing, if in his or her opinion, competing would have a detrimental effect on that rider's health.

Procedure

All new riders shall be classified nationally 6 -12 months before the competition. From that time on, no changes in the classification is permitted, unless there are significant changes in the impairment. Following the assessment each rider is given a Profile of Functional Ability. The rider will be given a copy of the assessment card. Later an I.P.E.C./F.E.I. Card will be sent to the rider on which is printed the Profile of Functional Ability and the sanctioned compensating aids allowed for riding in I.P.E.C., F.E.I. competition, and national competitions, where the national riding for the disabled association has made suitable arrangements with the National Equestrian Federation.

Classification shall be carried out in a courteous and professional manner, with appropriate testing only. At international competitions, the national classification will be checked by an international classifier the previous day or during the training period before the competition. During the classification, only the necessary personnel shall be present: the rider and one other, who shall either be the rider's Chef d'Equipe, team physiotherapist, or another person requested by the rider to act as their representative.

The rider's representative shall not speak during the classification process unless directly addressed, or unless a protest is made to preserve the dignity of the rider. The rider has a right to terminate the classification process at any time, for a valid reason. If the rider terminates the classification for any reason, that rider may be asked to withdraw from the competition. If a rider refuses to be classified this will automatically exclude him or her from the competition. If a protest is made, either of the procedure, or of the result of the classification, that protest must be investigated as soon as possible by the Jury of Appeal.

All riders should be encouraged to be as able as possible, and to this end prostheses should be worn for riding, unless the type or shape of the prosthesis would disadvantage the rider or cause discomfort to the horse. All should be observed riding following their classification; this is to assess the classification, not the skill of the rider. They must then ride with all special equipment or prostheses as they may need. No rider shall be permitted to compete wearing or using any prostheses or special equipment that has not been included in the classification procedure.

CLASSIFICATION FOR INTERNATIONAL COMPETITION

Amongst riders with disabilities, there are many different types of impairments. To provide meaningful competition for the riders it is necessary that people of like levels of impairment can compete together. The "Profile System" fulfils this criterion. The same system should be used at international and national level competitions. The classification of impairment into easily recognised functional profiles, and the grouping of these profiles into grades for competition facilitates this aim. The Profiles are versatile but tight, easy to use and understand, and have been made sport specific. The locomotor Profiles are not disability (diagnosis) specific, but are based on the ability of the functioning part of the body.

In any sport, certain areas of the body are more important than others. A 'weighting system' has been designed to take account of the areas most important for riding. These weightings have been used in conjunction with the Profile System in order to produce more equitable competition, and group the profiles specific to riding.

During classification it is essential to ensure that only impairment is assessed, not skill. Riders must not be assessed riding, as this could pre-empt the competition, with an especially skilled rider appearing to be less impaired than is actually so. Occasionally it may be necessary to check the balance when mounted, but it should be sufficient to check the balance in a simulated position in the assessment room.

However, **all riders should be observed during practice and during competition by the classifiers** in attendance at the competition. This is to confirm that the impairment recorded during the assessment is the same as that seen when mounted. Any riders moving limbs that

were incapable of movement during the assessment, may be requested to attend a reclassification session. Video evidence and results of random muscle tests may be used as evidence in exceptional circumstances.

Riders with **recovering** and **deteriorating** conditions must be reclassified within 6 months of World Championships and Paralympic Games. It is up to the country to arrange for the reclassification. The rider can be checked at the above events, but in cases where there may be recovery, this could result in changing to a higher Grade.

Classification is a statement of fact, not a test, and the judgement of the rider's ability on the horse is the function of the competition not the classification. The purpose of the competition is to reward skill; classification must therefore not penalise those who have achieved a high skill level.

The grouping of profiles into Grades is designed in order that riders may compete against their peers, or, if their nation so wishes, at a higher level (against those with less impairment). Competing at a lower level (against those with greater impairment) is not allowed. To maintain fairness, unclassifiable impairments are excluded from competitions. See Page 8 Eligibility for I.P.E.C. competition.

All assessment forms will be maintained and managed with strict confidentiality in accordance with I.P.C. code of classification to protect the rights of the rider.

See also I.P.E.C. Rule Book Chapter V Para 22 to 22.9.

ACCREDITATION OF CLASSIFIERS

Workshops consisting of theory and practice are held for classifiers. Participants for the classifier's course must be suitably qualified and recognised by their national disability organisation. For international and national classifier status, they must be medical doctors or physiotherapists, preferably with good horse knowledge. Participants are accredited as International(I), National(N) or Advisory classifiers(A) according to their national experience and performance during the course.

Further details of the Profile Classification System may be obtained from I.P.E.C. Medical Sub-Committee. This Classification Manual is produced by I.P.E.C. Chief Classifier and Chairman of Sports and Classification Medical sub committee:

Dr Christine Meaden
Tel No. +44 1628 629601
Fax No. +44 1628 623684
Email: chris@meaden.co.uk

Classifier's Responsibility at an I.P.E.C. Event

1. Classification Procedure

- 1.1 It is recommended that two I.P.E.C. classifiers are present at any International Competition, and one of these classifiers should be of I.P.E.C. International status.
- 1.2 At Major Championships there should be three I.P.E.C. International classifiers from different nations.
- 1.3 Any classification cards completed at an event should be signed by two I.P.E.C. Classifiers, one of whom must be from a country other than that of the rider. That classification is acceptable for National competitions.
- 1.4 For International competitions, a rider can only be awarded international status following examination by two I.P.E.C. International Classifiers, one of whom must again be from a country other than that of the rider. The examinations do not have to be done at the same time and place.
- 1.5 Classifiers may not give definitive classification until the rider has been observed mounted, in practice and/or during competition at the discretion of the classifier(s).
- 1.6 The completed assessment card should be sent to the I.P.E.C. Chief Classifier. If confirmed by the I.P.E.C. Chief Classifier,
 - the card will be stamped and copied to the rider.
 - the rider's name will be added to the I.P.E.C. master list of classified riders.
 - after an appropriate check, the I.P.E.C. secretary will issue the rider with an I.P.E.C./ F.E.I. ID card on which the permitted compensating aids are recorded.
- 1.7 Any protests to be dealt with in accordance with I.P.E.C. procedures.

2. Invitation to Classifier

- 2.1 Each classifier must be invited to the competition by written invitation well in advance of the event.
- 2.2 The invitation should state clearly the venue, the dates and times of the classification process, and when the classifier is expected to arrive and when to leave. Classifiers should stay to watch the competition.
- 2.3 Where air travel is involved, the invitation should also state whether the classifier or the organisers shall arrange the flights. If there are any constraints on what flights can be used, details should be advised to ensure that they are acceptable.
- 2.4 The invitation should confirm that the classifier's expenses will be met as set out in the next section.
- 2.5 On receiving an invitation, a classifier is expected to respond without delay and to confirm acceptance or otherwise in writing as soon as possible.

3. Classifiers' Expenses

- 3.1 The competition organisers must undertake to meet all expenses incurred by classifiers, either by providing the facilities or by paying all their relevant costs.
- 3.2 The expenses must cover return travel from the classifier's home to the competition venue, accommodation and subsistence at the venue to a reasonable standard, and any other essential expenses.
- 3.3 Accommodation should be provided for the classifiers away from the riders if possible, and preferably near the judges and the Technical Delegate.

- 3.4 The organisers will arrange transport from the airport to the venue, and again for the return flight; also daily transport to and from the venue if necessary.

4. Competition Organiser Responsibilities

- 4.1 After the closing date of entries, the Organising Committee (OC) shall send to the I.P.E.C. Chief Classifier (c/o the I.P.E.C. Secretary) a list of all riders, their nation, listed Profile Number and the Grade that they are entered. The list will be checked and returned to the O.C., verifying those that are classified and a list of those that need to be classified, or re-examined.
- 4.2 The O.C. is responsible to schedule all necessary rider classifications to take place before the start of competition. Thirty (30) minute periods should be designated for each appointment, with adequate meal times and breaks scheduled for the classifiers. Riders shall be sent the date and time of their scheduled classification appointment prior to the event, or immediately upon their arrival at the competition.
- 4.3 A clean, private examination room shall be made available for all classification appointments. The room shall be equipped with an examination bed with a pillow, four or five chairs, a table and stool, drinking water and a towel. The area shall be large enough to accommodate the classifiers, the rider and the rider's representative.
- 4.4 An appropriate waiting area shall be provided nearby the examination room.
- 4.5 The classifiers shall be assigned an Administrative Assistant. In addition to administrative duties such as photocopying, the Administrative Assistant shall ensure that riders arrive for their scheduled appointments and communicate with team Chefs d'equipe if necessary, convey classification results to the O.C. as soon as possible, and arrange for riders to be assessed mounted, if required by the classifiers.
- 4.6 A private area is to be provided nearby the competition arena for the classifiers (including the host nation's own classifiers who wish to be present) to observe the riders and discuss their classification without being overheard.
- 4.7 For a rider to be assessed mounted, if required, the time and place are to be agreed upon by the rider, the O.C., Chef d'equipe, the Technical Delegate and the classifiers. This is a classification assessment, the rider's skill shall not be considered during this assessment.

ELIGIBILITY CRITERIA FOR I.P.E.C. COMPETITION

All riders must be classified to compete in I.P.E.C. sanctioned events. Those riders with a MINIMAL FUNCTIONAL DISABILITY must meet the I.P.E.C. criteria (See Base line scores) in order to compete in I.P.E.C. events. "Classification is neither intended to be comprehensive nor to be all encompassing. I.P.E.C. classification is not by definition, inclusive it is exclusive. Therefore, there is no legal liability to classify everybody. To say someone is "not eligible or not classifiable" is not to say they are not disabled. The severity of the disability is not in doubt, but some disabilities do not fit into the classification system" (M Riding Chair I.P.C. Classification Committee 2000)

In order to be eligible, a rider must have a medically diagnosed condition that causes a permanent impairment that can be measured objectively. Examples of conditions, diseases or disorders that may lead to permanent impairment are: paresis, amputation, partial to full joint ankylosis, upper motor neurone lesions, loss of sight, intellectual disability.

Findings such as minor soft tissue contracture, ligamentous instability, oedema, disuse atrophy, fatigue as in M.E. or fibromyalgia or symptoms such as pain and/or numbness without other eligibility criteria listed above shall not be considered a permanent physical disability. Of course these people may be quite disabled, but they are unclassifiable.

Those people who are not eligible because they are "unclassifiable" or do not meet the conditions for minimal functional disability are sometimes told they can compete at national events as Profile 42. These people can compete in an open competition if their respective country organises such a competition outside the 4 classes of an I.P.E.C. competition.

Procedure for establishing the medical diagnosis

In most cases the certificate of diagnosis (page 10) signed by the rider's General Practitioner is sufficient evidence of their impairment.

Some riders are asked to provide sufficient written evidence of their diagnosis or disorder detailing the nature, evolution, and prognosis of the condition. This documentation should include letters and reports detailing medical history, results of radiological examination, computerised axial tomography, magnetic resonance imaging, electromyography, nerve conduction studies or other diagnostic tests, as applicable for the individual's medical diagnosis.

Failure to produce such evidence, or evidence which is not consistent with the results of the classification tests and observation during practice and or competition will render the rider "unclassifiable" or "not eligible".

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CONSENT FOR CLASSIFICATION

(Please complete in English)

Explanation:

For a rider/driver to be eligible to compete in I.P.E.C. competitions, the rider/driver must be classified by an authorised I.P.E.C. equestrian classifier.

Failure to cooperate with the classifiers, or failure to complete a classification will lead to ineligibility to compete in the competition sanctioned by I.P.E.C.

If the rider/driver finds his/her ability to cooperate with the I.P.E.C. classifier limited by pain, the rider/driver has the option of being classified regardless of pain, or the rider/driver can refuse to be classified (therefore is ineligible). The rider/driver understands that every attempt will be made to minimise discomfort, but that classifiers are indemnified from any pain and suffering caused by the testing.

The following is an agreement by the rider/driver to undergo a functional classification test including a medical (bench) test and to be observed before and during competition.

I.....wish to be classified for I.P.E.C. competition.
(PLEASE PRINT FULL NAME)

I understand that the I.P.E.C. classification process involves a medical (bench) test and observation at any time. I understand that to be classified I must be willing to take part in all portions and cooperate fully with the classifiers.

I understand that to perform the medical (bench) test, the I.P.E.C. classifiers must examine all movements and muscle groups. I agree to undertake these tests, and I agree that the classifiers are indemnified from any pain and suffering I may experience in the course of the test.

Signature of rider/driver

Witness, Signature of guardian/manager/coach.....

Date.....

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CERTIFICATE OF DIAGNOSIS

FULL NAME

ADDRESS.....
.....

TELEPHONE NUMBER..... DATE OF BIRTH.....

REGION/HOME/COUNTRY..... MALE OR FEMALE (delete one)

CLUB/SCHOOL/UNIT.....

APPLICANT'S SIGNATURE.....

MEDICAL DETAILS

THIS SECTION TO BE COMPLETED BY A DOCTOR OF MEDICINE ONLY

NAME OF APPLICANT.....

DIAGNOSIS.....

ANY OTHER RELEVANT FACTORS, e.g. EPILEPSY, DIABETES, HEART DISEASE, HAEMOPHILIA. (Please note: In case of visual handicap Appendix 2 should also be completed).

I HEREBY CERTIFY THAT THE ABOVE-NAMED PERSON HAS THE DIAGNOSIS SPECIFIED ABOVE.

SIGNATURE OF DOCTOR.....

NAME AND ADDRESS OF DOCTOR.....
.....

N.B. Information disclosed on this form will be dealt with according to the IPC code of ethics for classification.

A GRAPHICAL REPRESENTATION OF PROFILES

		A Graphical Representation										
1	2	3	4	5								
6	7	8	9	10								
11	12	13	14	15								
16	17	18	19	20								
<table border="0"> <tr> <td> Normal function or minimal disadvantage</td> <td> Absence of limb</td> <td> Severely Incoordinate</td> <td> Deformity</td> </tr> <tr> <td> Paresis</td> <td> Incoordinate</td> <td> Paresis or incoordinate</td> <td> Wheelchair user</td> </tr> </table>					 Normal function or minimal disadvantage	 Absence of limb	 Severely Incoordinate	 Deformity	 Paresis	 Incoordinate	 Paresis or incoordinate	 Wheelchair user
 Normal function or minimal disadvantage	 Absence of limb	 Severely Incoordinate	 Deformity									
 Paresis	 Incoordinate	 Paresis or incoordinate	 Wheelchair user									

	<p>36</p> <p>Blind</p>	<p>37a</p> <p>Partially Sighted</p>	<p>37b</p> <p>Partially Sighted</p>	<p>38</p> <p>Deaf</p>
<p>Learning Impaired</p>				

— Normal function, minimal advantage + Absent limb ≡ Severely incoördinate - - - Deformity
 - - - Partially incoördinate ≡ Incoördinate = = = Partially incoördinate ♿

MEDICAL DEFINITIONS

Locomotor Dysfunction:	Profiles 1-31
Sensory Dysfunction:	Profiles 36-38
Cerebral Dysfunction:	Profile 39
Other Dysfunction:	Profile 42
Able Bodied:	Profile 48

- PROFILE 1:** FOUR LIMBS REDUCED IN FUNCTION. Severe spasticity, athetosis or paresis present in all limbs and trunk. Needs an electric wheelchair or personal assistant during daily life.
- PROFILE 2:** FOUR LIMBS REDUCED IN FUNCTION. Severe deformity, paresis or incoordination present in all limbs and trunk. Triceps non-functional against resistance, e.g. complete C5/6 lesion.
- PROFILE 3:** FOUR LIMBS REDUCED IN FUNCTION. Moderate deformity, paresis or incoordination present in all limbs and trunk. The finger flexors, extensors and intrinsics may be severely impaired, e.g. complete C6/7 lesion.
- PROFILE 4:** FOUR LIMBS REDUCED IN FUNCTION. Severe deformity, paresis, or absence of all limbs. Trunk less affected and sensation minimally affected.
- PROFILE 5:** FOUR LIMBS REDUCED IN FUNCTION. Moderate spasticity or athetosis present in all limbs and perhaps trunk. Can propel chair with difficulty, either with arms or legs.
- PROFILE 6:** FOUR LIMBS REDUCED IN FUNCTION. Minimal impairment in upper limbs, severe paresis or spasticity in lower limbs and trunk, e.g. complete C8/T1 lesion, or moderate wheelchair quadriplegic.
- PROFILE 7:** THREE LIMBS REDUCED IN FUNCTION. Severe deformity, paresis, spasticity, athetosis or absence of three limbs. Some trunk involvement. One limb may be only minimally affected, but use of a wheelchair is essential.
- PROFILE 8:** FOUR LIMBS REDUCED IN FUNCTION. Minimal paresis or spasticity in upper limbs, and moderate to severe spasticity or paresis of lower limbs. Intrinsic muscles of hands may be severely affected. Trunk normal.
- PROFILE 9:** LOWER LIMBS AND TRUNK REDUCED IN FUNCTION. Severe spasticity, athetosis, or deformity present in lower limbs and trunk. Unable to balance in sitting unsupported. (T1 – T5).
- PROFILE 10:** LOWER LIMBS REDUCED IN FUNCTION. Severe spasticity, athetosis, deformity, or paresis present in both lower limbs. Moderate trunk involvement (T5 – T10) If they are unable to move outside their base of support, they can be Profile 9.

- PROFILE 11:** LOWER LIMBS REDUCED IN FUNCTION. Moderate paresis, spasticity, athetosis or deformity present in both lower limbs and trunk. It may be possible to stand or walk but uses a wheelchair for activities of daily living. (T10 – L3) Must have some power in hip flexors and extensors.
- PROFILE 12:** FOUR LIMBS REDUCED IN FUNCTION. Severe paresis, spasticity, athetosis or deformity in all limbs and trunk. Able to walk in an unorthodox way. Balance and co-ordination grossly affected.
12a: spasticity or athetosis in all limbs and trunk.
12b: paresis or deformity in all limbs and trunk.
- PROFILE 13:** THREE LIMBS REDUCED IN FUNCTION. Moderate to severe paresis, spasticity, athetosis or deformity in three limbs. Trunk is affected. Balance in standing severely affected.
- PROFILE 14:** IPSILATERAL LIMBS REDUCED IN FUNCTION. Moderate to severe paresis, spasticity, athetosis or deformity in two limbs on the same side of the body. Trunk is usually involved.
- PROFILE 15:** IPSILATERAL LIMBS REDUCED IN FUNCTION. Slight to moderate paresis, spasticity, athetosis or deformity in two limbs on the same side of the body.
- PROFILE 16:** ONE UPPER LIMB REDUCED IN FUNCTION. Severe paresis, spasticity, athetosis or total absence of one upper limb.
- PROFILE 17:** TWO LOWER LIMBS REDUCED IN FUNCTION. Severe paresis, spasticity, athetosis or deformity of both lower limbs, but able to walk with two crutches or sticks.
17a: no functional pelvic movement. Unable to move out of base of support.
17b: normal pelvic movement.
- PROFILE 18:** TWO LOWER LIMBS REDUCED IN FUNCTION. Severe paresis, spasticity, athetosis or deformity of one lower limb. Moderate to slight impairment of other lower limb.
18a: no functional pelvic movement. Unable to move out of base of support.
18b: normal pelvic movement.
- PROFILE 19:** ONE LOWER LIMB REDUCED IN FUNCTION. Severe paresis, spasticity, athetosis or total absence of one lower limb.
19a: Stump 4ins. (10cm.) or less.
19b: Stump longer than 4ins. (10cm.) Measured from greater trochanter.
- PROFILE 20:** TWO LOWER LIMBS REDUCED IN FUNCTION. Moderate to slight paresis, spasticity, athetosis or absence of part of both lower limbs.
- PROFILE 21:** TWO UPPER LIMBS REDUCED IN FUNCTION. Severe paresis, spasticity, athetosis, deformity or absence of both upper limbs.
- PROFILE 22:** TWO UPPER LIMBS REDUCED IN FUNCTION. Moderate to slight paresis, spasticity, athetosis, deformity or absence of part of both upper limbs.

- PROFILE 23:** ONE LOWER LIMB REDUCED IN FUNCTION. Moderate to slight paresis, spasticity, athetosis or total absence of one lower limb below the knee.
- PROFILE 24:** ONE UPPER LIMB REDUCED IN FUNCTION. Moderate to slight paresis, spasticity, athetosis or total absence of one upper limb below the elbow.
- PROFILE 25:** FOUR LIMBS AND TRUNK REDUCED IN STATURE. Height of four foot three inches or below (129.5 cm)
- PROFILE 26:** FOUR LIMBS REDUCED IN FUNCTION. Moderate to slight paresis, spasticity, athetosis or deformity in all four limbs. Balance and gross coordination affected.
26a: moderate to slight spasticity or athetosis in all four limbs.
26b: moderate to slight paresis or deformity in all four limbs.
- PROFILE 27:** TWO CONTRALATERAL LIMBS REDUCED IN FUNCTION. Severe to moderate paresis, spasticity, athetosis, deformity or absence of opposite arm and leg.
- PROFILE 28:** TWO LOWER LIMBS REDUCED IN FUNCTION. Severe to moderate paresis or degeneration in both hips. Lower spine affected.
- PROFILE 29:** TWO UPPER LIMBS REDUCED IN FUNCTION. Severe to moderate paresis in both upper limbs.
- PROFILE 30:** TRUNK REDUCED IN FUNCTION. Severe to moderate paresis, or deformity in trunk or neck.
- PROFILE 31:** FOUR LIMBS REDUCED IN FUNCTION. Severe paresis, spasticity, athetosis or deformity in both lower limbs. Slight paresis, spasticity, athetosis or deformity in both upper limbs. Trunk also involved. Usually unable to move out of base of support. This profile can also be used for those with slight paresis, spasticity, athetosis or deformity in both lower limbs and severe paresis, spasticity, athetosis or deformity in upper limbs.
- PROFILE 32-35:** AVAILABLE FOR THE INTRODUCTION OF NEW PROFILES
- PROFILE 36:** TOTALLY BLIND. No light perception in either eye, up to light perception but inability to recognise the shape of a hand at any distance or in any direction. See Appendix two.
- PROFILE 37a:** PARTIAL SIGHT. From the ability to recognise the shape of a hand up to a visual acuity of 2/60 or visual field of less than 5 degrees. See Appendix two.
- PROFILE 37b:** PARTIAL SIGHT. From visual acuity above 2/60 up to a visual acuity of 6/60 or visual field of less than 20 degrees. See Appendix two.
- PROFILE 38:** DEAF. A loss of hearing of 50 decibels in the better ear at three frequencies, 500Hz, 1000Hz and 2000Hz.

PROFILE 39: LEARNING IMPAIRMENT. Those with a learning difficulty combined with a locomotor impairment can be allocated dual profiles. See Appendix one.

PROFILE 40-41: AVAILABLE FOR THE INTRODUCTION OF NEW PROFILES.

PROFILE 42: A DYSFUNCTION WHICH IS DIFFICULT TO MEASURE OR GRADE. The following conditions are covered by this profile:
Internal organ dysfunction or absence.
Wear and tear of joints due to advancing age.
General debilitating disease.
Obesity.
Osteochondritis.
Psychiatric conditions.
Skin diseases.
Haemophilia without locomotor dysfunction.
Epilepsy.
Learning disability. (Mild)

PROFILE 43-47: AVAILABLE FOR THE INTRODUCTION OF NEW PROFILES

PROFILE 48: ABLE-BODIED PEOPLE.

TRAINER'S GUIDE TO PROFILES OF IMPAIRMENT

- PROFILE 1:** Almost no use in four limbs. Need to use an electric wheelchair, or be pushed in a manual wheelchair. Usually has very poor trunk control.
- PROFILE 2:** Almost no use in four limbs, but can bend elbows and just about push a manual wheelchair. May need to use an electric wheelchair for long distances. Has poor trunk control.
- PROFILE 3:** Wheelchair user with very poor balance and inability to grip and release objects. Has poor trunk control.
- PROFILE 4:** Almost no use in all four limbs, but good trunk control. Usually able to push a wheelchair in some way. Mainly use their seat to control the movement of the horse.
- PROFILE 5:** Wheelchair user with difficulty controlling the limbs when trying to perform any activity. Often has moderate trunk control.
- PROFILE 6:** Wheelchair user with poor trunk control and slightly weak hands, or lack of control in the arms.
- PROFILE 7:** Wheelchair user with good use in only one arm; may need to use an electric wheelchair if unable to push a manual chair. Difficulty with trunk control.
- PROFILE 8:** Wheelchair user with some control of trunk and slightly weak hands or arms. Difficulty with trunk control.
- PROFILE 9:** Wheelchair user with good use in arms, but only upper trunk control. Unable to perform a pelvic tilt. No lower trunk control (T1-T5).
- PROFILE 10:** Wheelchair user with good use of trunk and arms, but unable to use the hips to assist trunk movement. Able to perform a pelvic tilt with difficulty. Difficulty with trunk control. (T5-T10)
- PROFILE 11:** Wheelchair user with good control of trunk, arms, and some control of hips. Good pelvic tilt. (T10-L3) May have both legs absent.
- PROFILE 12:** All 4 limbs severely impaired, but able to walk. Fair to moderate trunk control.
12a: Severe difficulty controlling all four limbs when performing an activity.
12b: Severe deformity or weakness in all four limbs.
- PROFILE 13:** Able to walk, but has poor use of three limbs and usually uses a stick in the good hand. Trunk control varies, it is often fair to moderate.
- PROFILE 14:** Able to walk, but one side of the body is of little use; usually can only balance unaided only on the good leg. The imbalance of the body makes it difficult to balance on the horse.
- PROFILE 15:** Able to walk, but one side of the body is minimally impaired. Although there is imbalance it is easier to balance on the horse.

- PROFILE 16:** One upper limb absent or with little or no use.
- PROFILE 17:** Able to walk, but both lower limbs are severely impaired, acting more like props. May need crutches or sticks to walk.
17a: Very little or no functional use of pelvis. Unable to control the horse from the pelvis.
17b: Good control of pelvis. Able to control the horse from the pelvis.
- PROFILE 18:** Able to walk, but one limb severely impaired, used like a prop, the other leg better but not normal.
18a: Very little or no function in pelvis. Unable to control the horse from the pelvis.
18b: Good control of pelvis. Able to control the horse from the pelvis.
- PROFILE 19:** Able to walk, one leg severely impaired, used like a prop, other leg normal.
19a: An amputee who rides without a prosthesis. Stump 4ins. (10cm.) or less.
19b: Paresis or an amputee who rides with a prosthesis.
- PROFILE 20:** Able to walk and run but both legs impaired slightly e.g. a slight to moderate diplegic. (50% or less of the lower leg remaining)
- PROFILE 21:** Both arms severely impaired or may be absent.
- PROFILE 22:** Both arms slightly impaired or missing below the elbow, but able to grip reins with or without prosthesis. Base line scores will be used to determine if rider is eligible for I.P.E.C competitions.
- PROFILE 23:** One leg slightly impaired or absent below the knee, (50% or less of lower leg remaining), can usually run if fit enough. Amputation through the forefoot is not eligible.
- PROFILE 24:** One arm slightly impaired, unable to grip rein with one hand. Base line scores will be used to determine if rider is eligible for I.P.E.C. competitions.
- PROFILE 25:** Very short stature due to extreme shortness of limbs. (i.e. achondroplasia) Height of four foot three inches or below (129.5 cm)
- PROFILE 26:** Mild impairment in all four limbs.
26a: Impairment of coordination
26b: Impairment of power or range
- PROFILE 27:** Opposite arm and leg severely impaired or absent.
- PROFILE 28:** Both hips impaired causing difficulty walking, usually a waddling gait. The hip impairment must be sufficient to cause poor or no pelvic control.
- PROFILE 29:** Both shoulders impaired.
- PROFILE 30:** Deformity or weakness of trunk.

- PROFILE 31:** Able to walk, but both legs severely impaired. Arms moderately to slightly impaired. Trunk control varies, it is often fair to moderate.
- PROFILE 36:** Totally blind. (B1)
- PROFILE 37:** Visually impaired. See Appendix two.
37a: Partially sighted (B2)
37b: Partially sighted (B3)
- PROFILE 38:** Hearing impaired.
- PROFILE 39:** Learning impaired. IQ below 70. See Appendix one (This is under review).
- PROFILE 42:** A non-specific impairment that is variable and difficult to measure or grade. For example: obesity, asthma, skin disease, epilepsy, haemophilia, wear and tear of joints due to advancing age, lack of, or problems with internal organs, pain caused by conditions which do not result in objective impairment, and general debilitating disease.
- PROFILE 48:** Able bodied people.

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DRESSAGE FOR RIDERS WITH DISABILITIES

GRADE	PROFILES
ER Ia	1, 2, 3, 5, 7, 12a, 13
ER Ib	4, 6, 9, 12b

Mainly wheelchair users with poor trunk balance and or impairment of function in all four limbs, or no trunk balance and good upper limb function, or moderate trunk balance with severe impairment of all 4 limbs.

Grade ER Ia and Grade ER Ib may be combined.

ER II	8, 10, 11, 14, 17a, 18a, 27, 31
-------	---------------------------------

Mainly wheelchair users, or those with severe locomotor impairment involving the trunk and with good to mild upper limb function, or severe unilateral impairment.

ER III	15, 17b, 18b, 19a, 21, 25, 26a, 28, 36, 39
--------	--

Usually able to walk without support. Moderate unilateral impairment, or moderate impairment in four limbs, severe arm impairment. May need a wheelchair for longer distances or due to lack of stamina. Total loss of sight in both eyes, or intellectually impaired. Blacked out glasses or blind fold must be worn by Profile 36 riders.

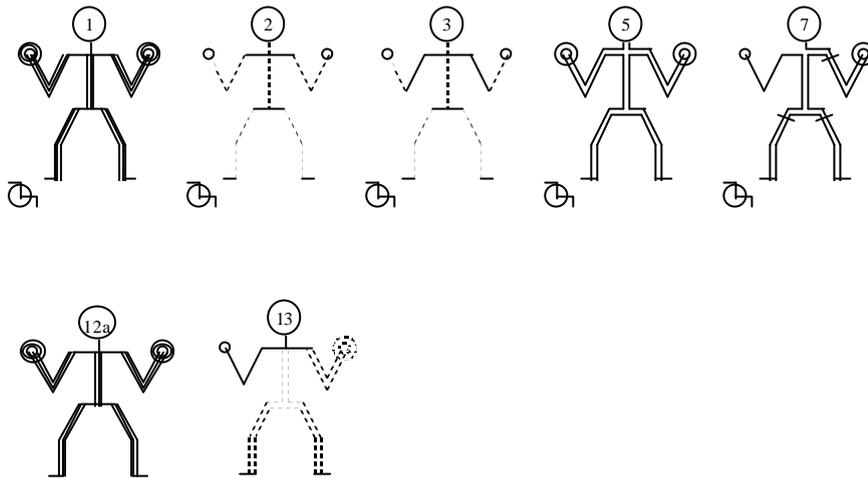
ER IV	16, 19b, 20, 22, 23, 24, 26b, 37a
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Impairment in one or two limbs, or some visual impairment.

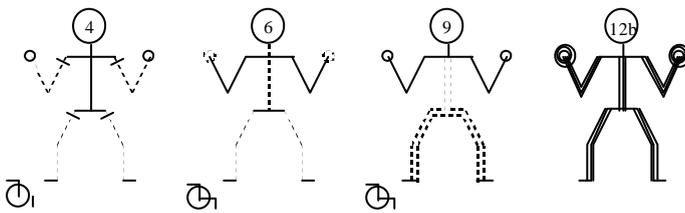
ER V Not eligible	29, 30, 37b, 42, 48
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DRESSAGE FOR RIDERS WITH DISABILITIES - ILLUSTRATED

Grade ER Ia

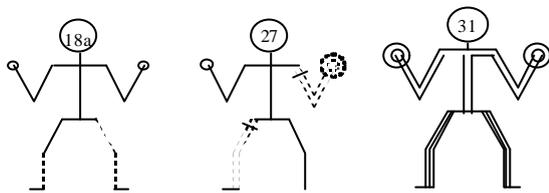
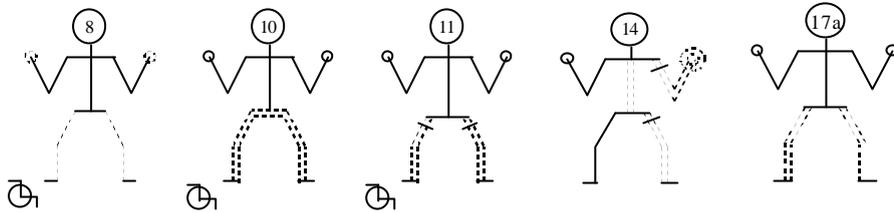


Grade ER Ib

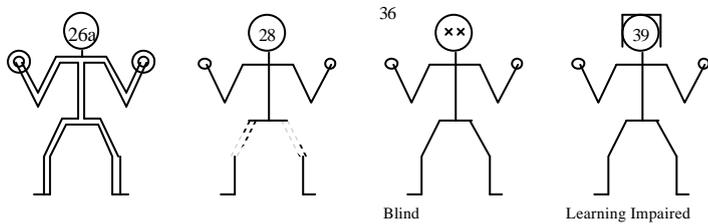
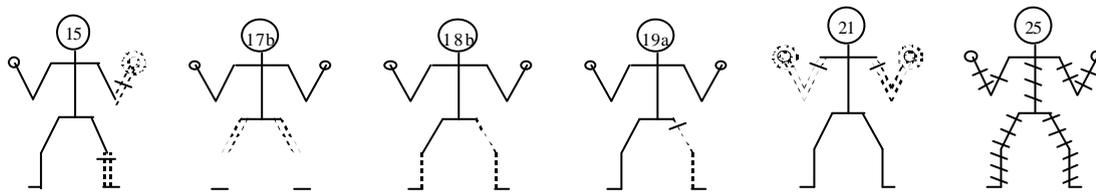


— Normal function or minimal disadvantage	+ Absence of limb	=== Paresis or incoordinate
- - - Paresis	≡ Incoordinate	≡≡≡ Deformity
	≡≡≡ Severely incoordinate	⊖ Wheelchair user

GRADE ER II

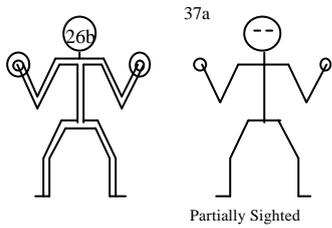
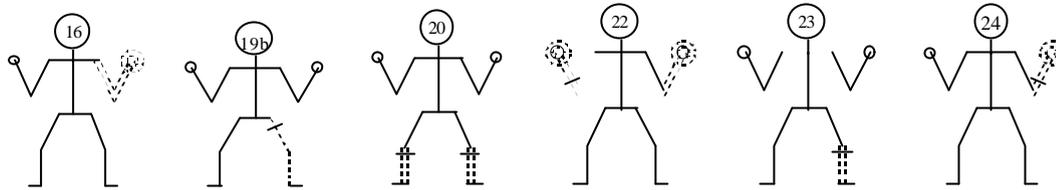


GRADE ER III



—	Normal function or minimal disadvantage	⊥	Absence of limb	===	Paresis or incoordinate
- - -	Paresis	≡	Incoordinate	⚙	Deformity
		≡≡≡	Severely incoordinate	⊥	Wheelchair user

GRADE ER IV



—	Normal function or minimal disadvantage	⊥	Absence of limb	===	Paresis or incoordinate
⊖	Paresis	≡	Incoordinate	≡≡≡	Deformity
		≡≡≡	Severely incoordinate	♿	Wheelchair user

ASSESSMENT CARD

CONFIRMATION AT EVENT
 EVENT _____
 DATE _____
 NOTES RE: PROFILE

 NAME: _____
 NATIONALITY: _____
 NAME: _____
 NATIONALITY: _____
 NAME: _____
 NATIONALITY: _____
SIGNATURES
 1. _____
 2. _____
 3. _____

RANDOM DRUG TESTING
 EVENT _____
 RESULT _____
 COMMENT _____

EVENT _____
 RESULT _____
 COMMENT _____

PROFILE/CLASSIFICATION DETAILS

PROFILE **GRADE**

WEIGHT	BODY PART	PROPRIOCEPTION	SYMMETRY	SENSATION
1	CERVICAL SPINE			
2	SHOULDER GIRDLE			
3	ELBOWS			
4	HANDS			
5	THORACIC SPINE			
6	LUMBAR SPINE			
7	PELVIS			
8	HIPS			
9	KNEES			
10	FEET			

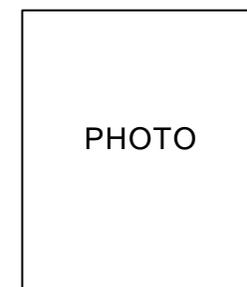
MARK WITH "X" IF AFFECTED

DATE OF CLASSIFICATION: _____
 DOCTOR/PHYSIO NO.1: _____
 SIGNATURE: _____

DATE OF CLASSIFICATION: _____
 DOCTOR/PHYSIO NO.1: _____
 SIGNATURE: _____

NOTE: PLEASE USE DARK INK AND BLOCK CAPITALS
 SURNAME: _____ MR/MRS/MISS/MS
 FORNAMES: _____
 DATE OF BIRTH: _____
 GROUP/CLUB/SCHOOL: _____
 HOME COUNTRY: _____
 HOME ADDRESS: _____

 _____ POSTCODE: _____
 COUNTRY: _____
 TELEPHONE: _____



SIGNATURE OF COMPETITOR

METHOD OF ASSESSMENT

The locomotor impairment is measured on a 0-5 scale, and recorded on the International Paralympic Equestrian Assessment Card (IPEAC). It is necessary to measure and **record only the relevant impairment**, whether power, range, or coordination. For example: impairment of power is measured for complete spinal lesions, impairment of range is measured for those with congenital deformities, impairment of coordination for those with cerebral palsy, or head injuries. Impairment of sight, hearing, or learning can also be recorded on the card, but the relevant form for visual or intellectual impairment must also be completed. (Appendix one or two).

Muscle Testing (Power scale)

- 0 - Total lack of voluntary contraction
- 1 - Faint contraction without any movement of the limb (trace, flicker)
- 2 - Contraction with very weak movement through full range of motion when gravity is eliminated (poor)
- 3 - Contraction with movement through the complete joint range against gravity
- 4 - Contraction with full range movement against gravity and some resistance (good)
- 5 - Contraction of normal strength through full range of movement against full resistance.

(Daniels and Worthingham 1980)

Joint Range Scale

- 0 - No movement possible
- 1 - Less than 25% movement possible
- 2 - 25% range of movement possible
- 3 - 50% range of movement possible
- 4 - 75% range of movement possible
- 5 - 100% range of movement possible

(Blomquist1985)

Co-ordination scale

- 0 - Activity impossible
- 1 - Severe impairment; only able to initiate activity without completion
- 2 - Severe impairment; able to accomplish the activity but in a very unorthodox way
- 3 - Moderate impairment; able to accomplish the activity, movements are slow, awkward and unsteady
- 4 - Minimal impairment; able to accomplish the activity with slightly less than normal speed and skill.
- 5 - Normal performance

(O'Sullivan, Cullen and Smith 1981)

NB: For people whose main problems are spasticity, athetosis or perceptual, it is not necessary to muscle test, or joint range test. Fine coordination is recorded as an overall score for each limb.

Balance Testing

STATIC BALANCE: Test in sitting and in standing by rhythmic stabilization. Can score as follows:

Good – 5 Slightly affected – 4 Moderately affected – 3 or 2 None – 1 or 0

DYNAMIC BALANCE : Test in sitting on edge of bed with feet supported (if possible). Score on either power, range **or** coordination column on assessment card.

Alternative ways of testing trunk.

Test pelvic tilt. Score as for static balance (5-0) in right and left columns.

Test upper flexion and extension. Score as for static balance (5-0) in right and left columns.

Test side flexion by sitting in anterior tilt with arms out to the side, then moving the upper body sideways away from mid line. Score as for static balance (5-0) in right and left columns.

Test rotation by sitting with arms out to the side, then rotating the body each way. Score as for static balance (5-0) in right and left columns.

DECIDING THE PROFILE

On completion of the assessment, the Illustrations (Pages 13 and 14) should be studied. Wheelchair competitors are illustrated as Profiles 1 through 11; Standing competitors are illustrated as Profiles 12 through 31. Decide on the nearest illustration, the medical definition (Page 15 through 18) should be read to confirm the choice. In all cases the score should be calculated. The profile number nearest to the competitors' presenting dysfunction is pencilled in on the card (put an alternative if uncertain e.g., Profile 14 or 15). In difficult cases, the decision is left to a panel of three, which should include a representative from I.P.E.C. (or the national governing body in the case of national assessments).

In particular cases, the competitor may need to be observed before, and during competition. In some cases, the international profile given by the chief classifier or medical sub committee may be different from that estimated by national classifiers. This is because riders are continually assessed by observation. Clarification of the reason for allocation of a different profile can be obtained from the I.P.E.C. chief classifier.

If the diagnosis and the presenting impairment are not compatible, a certificate of diagnosis completed by the rider's GP or Specialist must be brought to the classification session. It is essential that all M.S. sufferers produce a completed certificate of diagnosis at that time.

Competitors may be given two profiles. This means that they have more than one type of impairment, and the more severe impairment dictates the grade at which they compete. For example, Profile 36 + 20 is a totally blind (P36) mild diplegic (P20), and would compete at Grade III. A person with epilepsy or asthma (P42) with a physical disability such as hemiplegia (P14) would be eligible to compete as Profile 14, Grade II rather than P42 (Grade V).

These are examples of dual profiles. This table should be consulted for deciding the grade for dual profiles.

PROFILE 21+ 30	=	Grade III
PROFILE 37A+ 26 + 39	=	Grade III
PROFILE 16+ 30 + 24	=	Grade III
PROFILE 15 + 23	=	Grade III
PROFILE 37a + 38	=	Grade III
PROFILE 19b + 24	=	Grade III
PROFILE 36 + 38	=	Grade III
PROFILE 17b + 16	=	Grade II

DETERMINING BASE LINE SCORES

The base line scores are calculated by adding up the scores for each limb, trunk and neck. The scores have been evaluated from the collection of data over a 4 year period. The base line scores for each profile are listed on the next page. The scores are not recorded as a flat single dimensional number, but as a cluster of six numbers.

The maximum score for each arm is 80.

The maximum score for the neck is 40

The maximum score for the trunk is 60

The maximum score for each leg is 70

Thus an unimpaired body can be represented in the following way:

left arm - neck - right arm displayed as 80-40-80

left leg - trunk - right leg displayed as 70-60-70

Thus a severe left hemiplegic score for co-ordination could be :

40-40-80 Profile 14
40-50-70

This method of recording the score has more meaning than a flat score of 320 out of 400. A paraplegic could also score 320, but the impairment would be in a different part of the body. For example:

80-40-80 Profile 11
30-60-30

The measurement of the impairment is recorded at the clinical assessment (bench test). It is essential that all competitors are observed at regional, national and international events by medical assessors and sports technicians. If a competitor appears to be incorrectly categorised, the profile should be checked by comparison with the information recorded on the assessment card. If the competitor is observed to be using parts of the body which appeared impaired on clinical assessment, but that rider does not comply with the functional description of that group of competitors, the profile and group can be changed by two observers, provided one is a member of the I.P.E.C. Sports Medical and Classification subcommittee (or national medical sports committee if appropriate). All observation comments must be recorded on the card, endorsed by the signatures of the observers.

Base-line scores should be used only by people who have attended a Profile System Workshop, as organised by I.P.E.C.

BASE LINE SCORES FOR EACH PROFILE

Maximum score is: 80-40-80
 70-60-70

Maximum score allowed for each part of the body using 15% loss of impairment:

Neck	34	Upper limbs	68
Trunk	50	Lower limbs	60

Maximum score allowed for each profile:

PROFILE 1	35-40-35 25-20-25	PROFILE 12b	50-40-50 45-60-45	PROFILE 21	30-40-30 70-60-70
PROFILE 2	45-40-45 20-30-20	PROFILE 13	80-40-50 45-60-45	PROFILE 22	68-40-68 70-60-70
PROFILE 3	55-40-55 20-30-20	PROFILE 14	80-40-48 70-50-40	PROFILE 23	80-40-80 70-60-60
PROFILE 4	45-40-45 30-60-30	PROFILE 15	80-40-68 70-60-60	PROFILE 24	80-40-68 70-60-70
PROFILE 5	45-40-45 40-60-40	PROFILE 16	80-40-30 70-60-70	PROFILE 25	60-40-60 50-60-50
PROFILE 6	68-40-68 20-30-20	PROFILE 17a	80-40-80 40-40-40	PROFILE 26a	68-40-68 60-50-60
PROFILE 7	80-40-45 45-50-45	PROFILE 17b	80-40-80 40-60-40	PROFILE 26b	68-40-68 60-60-60
PROFILE 8	68-40-68 45-60-45	PROFILE 18a	80-40-80 60-40-15	PROFILE 27	80-40-30 30-60-70
PROFILE 9	80-40-80 20-30-20	PROFILE 18b	80-40-80 60-60-30	PROFILE 28	80-40-80 50-50-50
PROFILE 10	80-40-80 20-50-20	PROFILE 19a	80-40-80 70-60-15	PROFILE 29	50-40-50 70-60-70
PROFILE 11	80-40-80 30-60-30	PROFILE 19b	80-40-80 70-60-30	PROFILE 30	80-40-80 70-50-70
PROFILE 12a	50-40-50 45-50-45	PROFILE 20	80-40-80 60-60-60	PROFILE 31	68-40-68 45-60-45

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CARRIAGE DRIVING FOR PEOPLE WITH DISABILITIES

GRADE

PROFILES

CD I

1, 2, 3, 4, 5, 6, 7, 9, 12, 13, 14, 21, 22, 26a, 31

Wheelchair users with poor trunk balance and impairment in upper limbs, or those who are able to walk but with impairment of function in all four limbs, or those with severe arm impairment only.

CD II

8, 10, 11, 15, 16, 17, 18, 19, 25, 26b, 27, 28

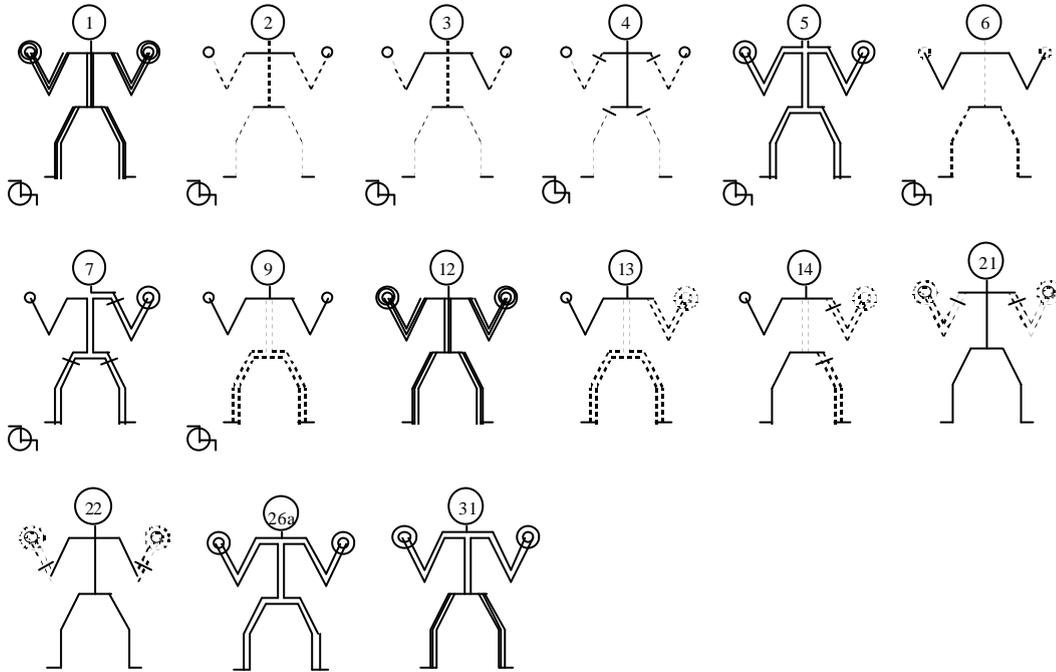
Those with less impairment than grade I, yet are functionally disadvantaged against able bodied drivers.

Not eligible for
international
competition

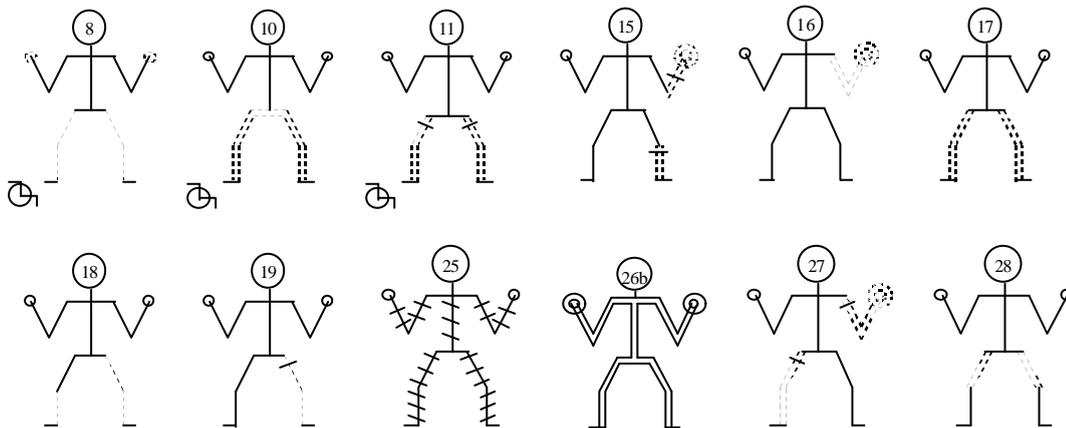
20, 23, 24, 29, 30, 36, 37a, 37b, 38, 39, 42, 48

CARRIAGE DRIVING FOR PEOPLE WITH DISABILITIES- ILLUSTRATED

GRADE CD I



GRADE CD II



—	Normal function or minimal disadvantage	⊥	Absence of limb	===	Paresis or incoordinate
- - -	Paresis	==	Incoordinate	≡≡≡	Deformity
		≡≡≡	Severely incoordinate	⊖	Wheelchair user

Appendix One

FORMS FOR ASSESSING INTELLECTUAL DISABILITIES

At the time of going to print the policy and procedure for assessing intellectual disabilities by the International Sports Federation for Persons with Intellectual Disability (INAS – FID) has not been verified by IPC.

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**INTERNATIONAL PARALYMPIC
EQUESTRIAN COMMITTEE
I.P.E.C.**

I.P.C. Sports Assembly Executive Committee

VISUAL IMPAIRMENT

THIS SECTION TO BE COMPLETED BY AN OPHTHALMOLOGIST OR OPTICIAN:

PLEASE NOTE: The examination must be carried out with the best possible correction (i.e. with optical aids). Please record

NAME OF APPLICANT.....

ADDRESS.....

DATE OF BIRTH.....

I HEREBY CERTIFY THAT AN EXAMINATION OF THE ABOVE-NAMED PERSON HAS BEEN CARRIED OUT AND THE FOLLOWING WERE RECORDED:

Acuity (in vision units Snellen) Please record over 60 rather than 36 or 24	Field Please provide print out if necessary
Right Eye	
Left Eye	

NB: To qualify for a classification
The competitor's vision in his/her
best eye (with best correction) must
fit into the stated ranges.

COMPETITIVE GROUPS:

PROFILE 36 (B1) No light perception in either eye, up to light perception, but inability to recognise the shape of a hand at any distance or direction.

PROFILE 37a (B2) From ability to recognise the shape of a hand up to a visual acuity of 2/60 or visual field of less than 5 degrees.

PROFILE 37b (B3) From visual acuity above 2/60 up to a visual acuity of 6/60 or a visual field of less than 20 degrees.

SIGNED..... DATE.....

NAME, ADDRESS, TELEPHONE AND QUALIFICATIONS OF SIGNATORY:

.....
.....

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Appendix Three **LIST OF CLASSIFIERS**

International Classifiers

AUSTRALIA	Miss Sharyn Gregory, P.T.	NEW ZEALAND	Mrs Vicky Melville, P.T.
AUSTRIA	Dr Christa Walter, M.D.		Mrs Mary Bradley, P.T.
CANADA	Dr Gillian Lawrence, M.D.	NORWAY	Mrs Tone Grinde, P.T.
	Mrs Wendy Roberts, P.T.	SWEDEN	Dr Magnus Sundblad, M.D.
CZECH			Ms Charlotte von Arbin, P.T.
REPUBLIC	Dr Jana Kulichova, M.D.	U.K.	Dr Christine Meaden- Chief Classifier
DENMARK	Mrs Vibeke Oleson, P.T.		Mrs Joyce Sherriff, P.T.
GERMANY	Dr Susi Fieger, M.D.	U.S.A.	Ms Joann Benjamin, P.T.
IRELAND	Mrs Bettina Jeffers, P.T.		Dr Susi Deusinger, PhD, PT
JAPAN	Dr Masamichi Maeda, M.D.		Mr James Little, P.T.
NETHERLAND	Dr Emile Keuter, M.D.		
	Dr Ad van Vliet, M.D.		

National Classifiers

AUSTRALIA	Ms Sue Blenkhorn, P.T.		Mr Yasuhiro Miyake, P.T.
	Miss Jane Buckley, P.T.		Ms Jyunko Nishida, P.T.
	Miss Nicky Bushell, P.T.		Ms Munehiro Shibayama, P.T.
	Ms Lisa Deelen, P.T.	NORWAY	Miss Anne Lanaman, P.T.
	Ms Veronica Gudenus, P.T.		Mrs Tina Felding, P.T.
	Mr Gill King, P.T.	RUSSIA	Dr Alexander Denisenkov, M.D.
	Mrs Margaret Lee, P.T.		Dr Elena Denisenkova, M.D.
	Mrs Wendy Mapleson, P.T.		Ms Ksenia Godunova
	Mr Don Perriman, P.T.		Dr Ekaterina Ghouravleva, M.D.
	Mrs Jill Shelton, P.T.		Miss Inna Kirienkova, P.T.
	Ms Susan Vincent, P.T.		Dr Larisa Kolesnik, M.D.
	Ms Liz Williams, P.T.		Dr Marina Kolosova, M.D.
AUSTRIA	Dr Helmut Lutz, M.D.		Dr Oleg Leonkin
BERMUDA	Mrs Jeni Southern, P.T.		Ms Natalya Leshchenco
CANADA	Miss Moira		Ms Elena Namazova
	Reed-Davis, P.T.		Ms Natalia Rindina
	Miss Judy Brooks, P.T.		Ms Ekaterina Skobina
CROATIA	Dr Zlatco Mandic, M.D.	SLOVENIA	Dr Miro Gorenssek, M.D.
CZECH	Dr Alexandra	SOUTH AFRICA	Ms Elsa Matthee, P.T.
REPUBLIC	Vosatkova, M.D.		Ms Ansie van der Walt, P.T.
	Ms Vanda Caskova, P.T.	U.K.	Mrs Jane Crowe, P.T.
	Ms Vitka Ziskalova, P.T.		Mrs Caroline Elwood, P.T.
	Ms Arnosika Jeskova, P.T.		Mrs Fiona Fummey, P.T.
	Ms Monika Wimmerova, P.T.		Mrs L. Lawford, P.T.
FINLAND	Dr Anna-Kaarina Kallis, M.D.		Mrs Mary MacLachlan, P.T.
	Mrs Helena Tigerstedt, P.T.		Mrs Chris Morgan, P.T.
FRANCE	Mr Gerard Le Gall, P.T.		Mrs A. Pell, P.T.
	Dr Elizabeth Schaal, M.D.		Mrs Phillippa Richmond, PT
GERMANY	Dr Jan Holger-Holtschmitt, M.D.		Mrs Susannah Solt, P.T.
	Dr Sabine		Miss Gerry Walker, P.T.
	Staemmler-Kienzle, M.D.	U.S.A.	Miss Angela Bennett, P.T.
ISRAEL	Ms Nathalia Pomerantz, P.T.		Mrs Una Bradley, P.T.
JAPAN	Ms Hidifumi Kamatani, P.T.		Mrs Bonnie Cunningham, P.T.
	Dr Ikuro Komai, M.D.		Mrs Cindy Thomas, P.T.
	Ms Norihisa Matsukawa, P.T.		Mrs Tina Wenz, P.T.

For queries and further information please contact the following:

I.P.E.C. Chairman

Mrs Jonquil Solt,
Blackdown Farm,
Leamington Spa,
Warwks CV32 6QS
U.K.

Tel.44 1926 422522
Fax.44 1926 450996
jonquil@solt.demon.co.uk

I.P.E.C. Chief Classifier

Dr Christine Meaden PhD MCSP
9 Bloomfield Road
Maidenhead,
Berks SL6 4NS
U.K.

Tel.44 1628-629601
Fax.44 1628-623684
chris@meaden.co.uk

I.P.E.C. Secretary

Mrs Sue Adams
47 Prince's Court,
London SE16 7TD
U.K.

Tel.44 20 7394 7747
Fax.4420 7394 0737
smradams@btinternet.com