

WWR WAR-P Registration

Revised 15 Nov 2011

Date: _____

Instructions:

A. Complete registration, medical questionnaire & public affairs form. Indicate N/A for any questions that do not apply to Veterans. Veterans must include DD214 Member 4 copy.

B. Return documents through chain of command or to WWSports@usmc.mil. For questions, email WWSports@usmc.mil or call 571-357-6316

It is requested that I be considered for participation in: _____

(Specify EVENT or CAMP & DATES)

1. NAME (LAST, FIRST, MI)		2. Rank	3. SSN		4. Cell				
					Do you text? Y N				
5. Current Duty Station/DET	6. Parent Command	7. Current Mailing Address			8. Current Duty Status & EAS				
9. Home email				10. Are you medically retired from DoD? Y N If Veteran, list DoD Rating: _____% and VA Rating: _____%					
11. Date of Birth		12. Gender		13. Height		14. Weight			
15. Primary Emergency POC (Name, Phone, Relationship)					16. Are you a member of Team Semper Fi? Y N Are you a member of Operation Rebound (CAF)? Y N				
17. Secondary Emergency POC (Name, Phone, Relationship)					18. Airport flying from				
19. Do you have a GTCC (gov't credit card)? Y N	20. Hand (Check) Right Handed Left Handed	21. Sizes (circle each)		Polo	T-Shirt	Warmup Top	Warmup Bottom	Shorts	Shoe Size
		Swimsuit Waist Size		S	S	S	S	S	
22. Do you have a personal credit card? Y N		Women's Sizes		M	M	M	M	M	
		Men's Sizes		L	L	L	L	L	
				XL	XL	XL	XL	XL	
				XXL	XXL	XXL	XXL	XXL	
23. Do you require a non-medical attendant? Y N	24. Do you REQUIRE first-floor room or elevator access? Y N		25. Do you REQUIRE an ADA-compliant room? (if regular room with shower chair is acceptable, then answer NO) Y N						

26. Sports experience during the past three years.

27. Why do you want to participate?

28. Specify injury or illness (above knee, below elbow, TBI, spinal cord, PTSD, cancer, etc)

29. How were you injured? Which unit were you with when you became ill or injured?

30. Additional considerations the staff should be award of (i.e. dietary, have working dog, etc.)

It is understood that this application must go through my proper chain of command. I certify that all information is correct and accurate.

31. Signature _____ **Date** _____

COMMANDER'S ENDORSEMENT (ACTIVE DUTY ONLY)

32. _____

Name and grade of Commander/OIC	Signature	Date	Phone
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PHYSICIAN ENDORSEMENT (ACTIVE DUTY & VETERAN - REQ'D IF NOT ON FILE WITH WWR WARP EVERY 6 MONTHS)

Name:	Installation/Location:	Phone:	Email:
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I have reviewed this application and the attached medical questionnaire. I verify that the named individual is qualified physically and mentally to compete in USMC or higher level competitions or trial camps.

Printed name of Primary Care Physician	Signature	Date
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Physicians, please indicate injury category(ies)

<input type="checkbox"/> Single Leg Amputee (BK)	<input type="checkbox"/> Single Leg Amputee (AK)	<input type="checkbox"/> Double Leg Amputee (BK)
<input type="checkbox"/> Double Leg Amputee (AK)	<input type="checkbox"/> Below Elbow Amputee (BE)	<input type="checkbox"/> Above Elbow Amputee (AE)
<input type="checkbox"/> Leg Impairment (BK) (Permanent)	<input type="checkbox"/> Leg Impairment (AK) (Permanent)	<input type="checkbox"/> Arm Impairment (BE) (Permanent)
<input type="checkbox"/> Arm Impairment (AE) (Permanent)	<input type="checkbox"/> Spinal Cord Injury (SCI)	<input type="checkbox"/> Post Traumatic Stress Disorder
<input type="checkbox"/> Traumatic Brain Injury (TBI)	<input type="checkbox"/> Visual Impairment (Corrected visual acuity of 20/200 or greater)	<input type="checkbox"/> Other: _____ (Temporary orthopedic, etc.)

Physical limitations: (additional comments on other side if necessary):