



California State Athletic Commission

1424 Howe Ave. Ste. #33
 Sacramento, CA 95825
 www.dca.ca.gov/csac/
 (916) 263-2195 FAX (916) 263-2197

**APPLICATION FOR AMATEUR ATHLETE****BOXING****KICKBOXING**

Your application will be considered "Pending" if any information is not completed.

One (1) passport sized photograph (2"x 2"). Physical Examination Report by licensed physician.	OFFICE USE ONLY			
	Date of Application: _____ Date License Approved: _____ License # and Exp. Date: _____ P/E Exp. Date: _____			
Section 1. Please print the following information:			Social Security Number:	
Last	First	Middle		
Address:				
Street (No PO BOX)	City	State	Zip Code	Country
Telephone number:				
Age:	Male / Female Circle one	Birth Date: (MM / DD / YYYY):	Height: ____ Ft. ____ In.	Weight: _____ pounds
Section 2. Please print the following information:				
Have you ever used any other name(s)? YES NO If yes, list name(s): _____				
Have you ever been disqualified in any competition? YES NO If yes, please explain: _____				
Section 3. Amateur boxing record:			Section 4. Amateur martial arts record:	
Wins: _____ Wins by KO/TKO: _____ Losses: _____			Wins: _____ Wins by KO/TKO/Submissions: _____	
Losses by KO/TKO: _____			Losses: _____ Losses by KO/TKO/Submissions: _____	

Revised December 2007

APPLICATION FOR AMATEUR ATHLETE

APPLICANT NAME: _____

Section 5. Please print the following information:

If you are now or have ever been licensed by the California State Athletic Commission, another athletic commission, or any similar governmental authority, provide the following information for each license, listing the most recent first:

TYPE OF LICENSE	LICENSE YEAR	STATE/OTHER COMMISSION/ GOVERNMENTAL AUTHORITY
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has your license ever been suspended, revoked or fined by the California State Athletic Commission, another athletic commission or any similar governmental authority? **YES NO** If YES, provide the following information:

TYPE OF LICENSE	ACTION TAKEN	REASON FOR ACTION	DATE OF ACTION
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are there charges pending against you by the California State Athletic Commission, another athletic commission or any similar governmental authority? **YES NO** If YES, provide the following information:

OFFENSE	DATE OF OFFENSE	GOVERNMENTAL AUTHORITY	HEARING DATE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you been convicted of a crime in the past 10 years? **YES NO** If YES, provide the following information:

OFFENSE	DATE OF CONVICTION	CITY, STATE, COUNTRY	SENTENCE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are there any charges pending against you by any law enforcement agency? **YES NO** If YES, provide the following information:

OFFENSE	DATE OF OFFENSE	CITY, STATE, COUNTRY	HEARING OR TRIAL DATE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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APPLICATION FOR AMATEUR ATHLETE

APPLICANT NAME: _____

Section 6. Please Print the Following Information:

EMERGENCY CONTACT INFORMATION:

Name _____ Relationship _____
Address _____ Phone Number _____
City _____ State _____ Zip Code _____ Country _____

PLEASE READ CAREFULLY

AUTHORIZATION TO RELEASE INFORMATION

Authority to provide the California State Athletic Commission with this information is established pursuant to Sections 18640, 18642 and 18643 of the Business and Professions Code. Disclosure of your social security number is mandatory pursuant to Section 30 of the Business and Professions Code and Pub. L.94-455 (42 USCA 405 © © authorizes collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes, and for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code. The social security number is also used to report and credit boxer pension fund payments in implementing Sections 18880, 18881, 18882, 18883, 18884, 18887, and 18888 of the Business and Professions Code. If you fail to disclose your social security number your application for initial or renewal license will not be processed AND you will be reported to the Franchise Tax Board, which may assess a \$100 penalty against you.

All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will result in the application being rejected as incomplete. The information provided will be used to determine qualification for licensure. Information on your application and physical examination report may be released to law enforcement agencies. Applicants have the right to review their application subject to the provisions of the Information Practices Act. The Executive Officer is the custodian of records.

APPLICANT DECLARATION

I declare under penalty of perjury under the laws of the State of California, that I have read the foregoing application for a professional athlete’s license and that all the answers given are my own. I further declare that all the answers are true AND THAT THE HIV/HBV/HCV TEST REPORT REPRESENTS MY HIV/HBV/HCV TEST RESULTS. I understand that any misstatement of material fact in this application will constitute grounds for denying or revoking the license.

Applicant’s signature: _____ Date: _____

This item is VOLUNTARY. You do not have to check this box.

I hereby authorize the California State Athletic Commission to release my telephone number to any commission licensee for contact purposes. This authorization shall be valid during the license year in which this application is signed.

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**AMATEUR ATHLETE PHYSICAL EXAMINATION**

Only a licensed Physician may conduct this examination and complete this form.
Please complete this form in its entirety.

BOXING**KICKBOXING**

Office Use
 Approved by: _____
 Date: _____

Last	First	Middle
Address:		
Street (No PO BOX)	City	State
		Zip Code
Country		
Telephone number:		
Age:	Male / Female Circle one	Birth Date: (MM / DD / YYYY):
PHYSICAL HISTORY: Please check all that applies below:		
<input type="checkbox"/> Asthma <input type="checkbox"/> Blood in urine <input type="checkbox"/> Allergies <input type="checkbox"/> Fainting spells <input type="checkbox"/> Rupture (hernia) <input type="checkbox"/> Chest pains <input type="checkbox"/> Operations <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Swollen joints <input type="checkbox"/> Rheumatism <input type="checkbox"/> Diabetes <input type="checkbox"/> Frequent headaches <input type="checkbox"/> Convulsions (fits) <input type="checkbox"/> Chronic cough <input type="checkbox"/> Spitting of blood <input type="checkbox"/> Cerebral hemorrhage or serious head injury If yes, please explain: _____		
When was the last time you took any type of medication or drug? (State what type and when and be specific):		

Have you ever undergone any type of surgery? Yes No (State what type and when and be specific):		

When was the last time you took any type of vitamin supplement? (State what type and when and be specific):		

Amateur boxing record:	Amateur martial arts record:	
Wins: _____ Wins by KO/TKO: _____ Losses: _____	Wins: _____ Wins by KO/TKO/Submissions: _____	
Losses by KO/TKO: _____	Losses: _____ Losses by KO/TKO/Submissions: _____	

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AMATEUR ATHLETE PHYSICAL EXAMINATION

APPLICANT NAME: _____

PHYSICAL EXAMINATION:

General appearance: _____ Height: _____ Weight: _____
Temperature: _____ Disabling scars: _____ Mouth: _____ Teeth: _____ Tonsils:
_____ Neck: _____ Pulse at rest: _____ Pulse after 100 hops: _____ Blood pressure: At
rest: _____ After 100 hops: _____ 2 minutes later: _____
Enlarged glands: Yes No – Goiter: Yes No – Heart: Pulse rhythm Regular Irregular –
Murmurs: Yes No – Musculoskeletal system: _____
Apical impulse: Heavy Normal - Enlargement: Yes No – Lungs: Rales Yes No
Abdomen: Enlargement of liver Yes No – Breasts: Mass Yes No – Tenderness Yes No –
Discharge Yes No – Enlargement of Spleen: Yes No – Hernia: Yes No –
Testicles: Normal Yes No
Remarks: _____

Reflexes: Pupils _____ Knee jerks _____ Romberg _____ Babinski _____
Skin: Tone _____ Rash _____ Boils _____ Other: _____
Unhealed wounds: _____
Remarks: _____

EYE HISTORY: Have you ever had any of the following conditions:

Blurred vision? Yes No – If YES, please explain in full: _____

Have you ever had any surgical procedures done to your eye(s) or the tissues around your eye(s) other than simple sutures of the skin around the eye?

Yes No – If YES, please explain in full: _____

Have you ever been diagnosed by a physician to have significant eye problems such as retinal detachment, retinal tear, primary or secondary glaucoma, aphakia, pseudophakia, or dislocated lens? Yes No – If YES, please explain in full: _____

EYE EXAMINATION:

Vision without glasses Right _____ Left _____

Vision with glasses Right _____ Left _____

Visual fields Right _____ Left _____

EXAMINING PHYSICIAN:

Based on your personal observation and review of the test results and considering Commission rules, is it your medical opinion that this applicant is physically fit to be licensed and compete in combative sports? **Yes No**

If no, please explain: _____

LICENSED PHYSICIAN'S NAME (print) _____	MEDICAL LICENSE NO. _____	APPLICANT NAME (print) _____
ADDRESS / CITY / STATE / ZIP CODE _____		APPLICANT SIGNATURE _____
TELEPHONE NO. _____	DATE/TIME _____	PERSON WHO ASSISTED'S NAME (print) _____
PHYSICIAN'S SIGNATURE _____		PERSON WHO ASSISTED'S SIGNATURE _____