California State Athletic Commission
2005 Evergreen Street, Suite 2010
Sacramento, CA 95815
www.dca.ca.gov/csac/
(916) 263-2195 FAX (916) 263-2197

Professional Boxer/Mixed Martial Arts/Kickboxing Athlete
APPLICATION INSTRUCTIONS

You must submit the actual application form before or with your medical documents and other licensing materials. Medical documents will not be accepted without an application form on file in the office.

1. APPLICATION FORM – Complete and sign. The Social Security Number is mandatory. Use your Social Security Number. It is a violation of federal law to use another person's SSN.

NOTE: The license will expire one year from the date the license is issued, i.e. a license issued on February1, 2007 will expire on January 31, 2008.

2. APPLICATION PROCESSING FEE – $60.00 Personal Check, Cashier's Check or Money Order enclosed.

3. PHOTOGRAPH – One recent passport sized photograph (2"x 2"). You may bring your own photograph or one can be obtained from the Commission.

4. NEUROLOGICAL EXAMINATION – Must be performed and completed by a licensed physician that specializes in neurology or neurosurgery.

NOTE: For the 2008 licensing year, an examination dated on or after September 1, 2007 will be valid for the entire 2008 calendar year. Examinations taken on or after January 1, 2008 will be valid until December 31, 2008, unless the Commission orders additional medical testing.

5. MRI (Brain Imaging Scan) – Must be performed by an approved medical practitioner. (Baseline) That means that unless you suffer an untoward pertinent medical event or suffer physical damage or injury through your career you will not need to take another scan. However, for health and safety reasons the Commission reserves the right to require you to undergo any medical testing to satisfy their understanding of your suitability to compete.

At a minimum, the MRI scan is to be performed on a 1.5 Tesla MR Machine with capabilities including fast spin echo and FLAIR imaging. Image sequences should include axial T1, T2, and FLAIR images; coronal images should be performed as a T2 coronal; and a single sagittal T1 sequence. Please take this report and the **MRI Review Summary** form to the Neurologist or Neurosurgeon that performed your neurological examination. Please forward the report and form immediately to the Commission.

As soon as possible, please arrange to have the images placed on a CD and forwarded to the Commission at: 1424 Howe Avenue, Suite 33, Sacramento, CA 95825. If a CD is not available, please forward the actual film within ten (10) days to avoid suspension of your license.

6. EKG – Must be performed by the licensed physician that performed your physical examination (Baseline). That means that unless you suffer an untoward pertinent medical event or suffer physical damage or injury through your career you will not need to take another scan. However, for health and safety reasons the Commission reserves the right to require you to undergo any medical testing to satisfy their understanding of your suitability to compete. Please have the Physician who conducted your Physical Examination review this report and complete an **Cardiovascular History.** Please forward the report and form immediately to the Commission.

7. OPHTHALMOLOGICAL EXAMINATION – Must be performed by an Ophthalmologist and is valid for a period of one-year. The examination may be performed out of state but it must be documented on a form approved by the Commission and completed and signed by the ophthalmologist. The examination will not be valid if it was performed within 24 hours of the bout. Please forward the report and form immediately to the Commission.

8. PHYSICAL EXAMINATION – Must be completed by a licensed physician. Valid for the one-year licensing period. Please forward the report and form immediately to the Commission.

9. BLOOD TESTS RESULTS for HIV antibody & HBV (Hepatitis B Surface Antigen) & HCV (Hepatitis C Antibody) must be submitted with this application on the letterhead of the laboratory that administered the tests. The laboratory must be certified by the Federal Clinical Laboratory Improvement Act. The blood tests must be taken **within 30 days** prior to the date of application. Results for the 2008 licensing year must be dated no later than 30 days from the date the 2008 application is submitted to the Commission. Please forward the report immediately to the Commission.

Example:

- Test results dated January 2, 2008 are valid for the next 30 days.
- Test results dated November 1, 2008 are valid for 180 continuous days.

Note: HIV, HBV & HCV tests must be retaken if the boxer or mixed martial arts athlete will be competing in a contest that will take place more than **180 days** from the date the initial tests were submitted for issuance or renewal of a license.

10. AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

11. BOXER'S PENSION PLAN ENROLLMENT FORM – Enrollment in the Boxer's Pension Plan is voluntary and there is no fee; however, you must complete the enrollment form with beneficiary information in order to be entered into the program so that your rounds are calculated for eventual payment of retirement benefits. Unless your beneficiary information or your contact information has changed you need not complete these documents if you have already done so.

BOXERS ONLY - Federal Identification (I.D.) Card

The Federal Boxing Act of 1997 requires every professional boxer to obtain a Federal I.D. card from his or her state of residence. If the boxer resides in a state or country where there is no boxing commission, the boxer must register in a state with a boxing commission. The boxer must appear in person at a Commission office and present a valid government issued photo identification with date of birth. Boxers must possess both the ID card and a valid license at the time of the weigh-in or he/she will not be allowed to compete.

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APPLICATION FOR PROFESSIONAL ATHLETE

BOXING MIXED MARTIAL ARTS KICKBOXING

You must submit all the items listed below before your application is processed.
Your application will be considered "Pending" if any information is not completed.

- **$60 Application Fee.**
- **One (1) passport sized photograph (2"x 2").**
- **Neurological Examination Report (by licensed physician specializing in neurology and/or neurosurgery).**
- **Physical Examination Report by licensed physician.**
- **Ophthalmologic Examination by licensed Ophthalmologist.**
- **Negative HIV, HCV Antibody (Hepatitis C), and HBV Surface Antigen (Hepatitis B) test results must be submitted on the letterhead of a CLEA certified laboratory in the United States.**
- **EKG Examination***
- **EKG Summary Report***
- **MRI Diagnostic Report***
- **MRI Summary Report***

***Baseline examinations. Only when ordered.**

OFFICE USE ONLY

Date of Application: ____________________

Date License Approved: ____________________
License # and Exp. Date: ____________________
Federal ID # and Exp. Date (Boxers only) : ____________________
Amount Rec'd: ____________ Method of Payment: ____________
Receipt #: ____________ Receipt given by: ____________
P/E Exp. Date: ____________ HIV Exp. Date: ____________
HBV Exp. Date: ____________ HCV Exp. Date: ____________
Ophthalmologic Exp. Date: ____________________
Neuro Exp. Date: ____________________
EKG Exp. Date: ____________________
MRI Diagnostic Report Date: ____________________

Section 1. Please print the following information: **Last** **First** **Middle**				**Social Security Number:**
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: ____________________
____

Has your license ever been denied, suspended or revoked in any state or country for medical reasons (OTHER THAN HIV, HBV, OR HCV)? YES NO If yes, please explain: ____________________
____

APPLICATION FOR PROFESSIONAL ATHLETE

APPLICANT NAME: ____

Section 3. Please print the following information:

Professional boxing record:

Wins: _______ Wins by KO/TKO: _______ Losses: ______

Losses by KO/TKO: _______

Amateur boxing record:

Wins: _______ Wins by KO/TKO: _______ Losses: ______

Losses by KO/TKO: _______

Section 4. Please print the following information:

Professional martial arts record:

Kickboxing Mixed Martial Arts

Wins: __________ Wins by KO/TKO/Submissions: ________
Losses: _______ Losses by KO/TKO/Submissions: ________

Amateur martial arts record:

Kickboxing Mixed Martial Arts

Wins: __________ Wins by KO/TKO/Submissions: ________
Losses: _______ Losses by KO/TKO/Submissions: ________

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

APPLICATION FOR PROFESSIONAL ATHLETE

APPLICANT NAME: ____

Section 6. Please Print the Following Information:

EMERGENCY CONTACT INFORMATION:

Name ____ **Relationship** __________________
Address ____ **Phone Number** _______________
City ____________________ **State** ___________________ **Zip Code** ________________ **Country** __________

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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PROFESSIONAL ATHLETE PHYSICAL EXAMINATION

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

Office Use
Approved by: ______
Date: ____________

BOXING **MIXED MARTIAL ARTS** **KICKBOXING**

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: **Asthma** **Blood in urine** **Allergies**

Fainting spells **Rupture (hernia)** **Chest pains** **Operations** **Shortness of breath** **Swollen joints**

Rheumatism **Diabetes** **Frequent headaches** **Convulsions (fits)** **Chronic cough** **Spitting of blood**

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):
____

Professional boxing record:

Wins: _______ Wins by KO/TKO: _______ Losses: ______

Losses by KO/TKO: _______

Amateur boxing record:

Wins: _______ Wins by KO/TKO: _______ Losses: ______

Losses by KO/TKO: _______

Professional martial arts record:

Kickboxing Mixed Martial Arts

Wins: __________ Wins by KO/TKO/Submissions: ________
Losses: _______ Losses by KO/TKO/Submissions: ________

Amateur martial arts record:

Kickboxing Mixed Martial Arts

Wins: __________ Wins by KO/TKO/Submissions: ________
Losses: _______ Losses by KO/TKO/Submissions: ________

PROFESSIONAL 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 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: ____
____

You must also go to an Ophthalmologist and undergo a Commission ATHLETE OPHTHALMOLOGIC EXAMINATION

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

December 2007-13

CALIFORNIA STATE ATHLETIC COMMISSION
2005 EVERGREEN ST. STE. 2010
SACRAMENTO, CA 95815
INTERNET: www.dca.ca.gov
(916) 263-2195 FAX (916) 263-2197

NEUROLOGICAL EXAMINATION REPORT

(Must be administered by a licensed physician who specializes in neurology or neurosurgery)

Last Name First Name Date of Birth

Street Address City State Zip Code

HISTORY

Is there anything in this athlete's past medical history that would cause you to recommend that the athlete not be licensed in California? Yes No (Circle One)
Please explain: ______

NEUROLOGICAL EXAMINATION

CRANIAL NERVES (1 – 5)

1. Pupillary size in MM **OD** _____ **OS** _____ ***Reactivity*** **OD** _____ **OS** _____
Note any asymmetry ______ **N/A** _____**(1)**
2. Fundus **OD** _____ **OS** _____ **N/A** _____**(2)**
3. Eye closure ______ **N/A** _____**(3)**
4. Extraocular motility visual pursuit _________ saccades _________ nystagmus _________
Describe any abnormality ______ **N/A** _____**(4)**
5. Palate elevation **N/A** _____**(5)**

MOTOR (6 – 9)

6. Strength **RUE** ______ **LUE** ______ **FILE** ______ **LLE** ______ **(0 – 5/5)**
List any abnormality ______ **N/A** _____**(6)**
7. Tone **RUE** ______ **LUE** ______ **FILE** ______ **LLE** ______
(I = increased D = decreased N = normal) **N/A** _____**(7)**
8. Range of motion **RUE** ______ **LUE** ______ **FILE** ______ **LLE** ______
Describe reason for restriction ______ **N/A** _____**(8)**
9. Abnormal movements (tics, chorea, choreiform, myoclonus, etc.) ______
Fasciulations ______
Describe any abnormal movements ______ **N/A** _____**(9)**

CEREBELLAR (10 – 15)

10. Finger – nose – finger *Describe any abnormalities* ______ **N/A** _____**(10)**
11. Heel – shin *Describe any abnormalities* ______ **N/A** _____**(11)**
Abnormal = 3 failures
12. Rebound check *Describe any abnormalities* ______ **N/A** _____**(12)**
Abnormal = 2 failures
13. Rapid alternating hand movements
Describe any abnormalities ______ **N/A** _____**(13)**
14. One foot hop (3 trails, 5 secs ea ft)
Describe any abnormalities ______ **N/A** _____**(14)**
15. Romberg *Describe any abnormalities* ______ **N/A** _____**(15)**

Athlete's Name:

GAIT (16)

16. Gait

Routine Gait __________ Heal Walk __________ Toe Walk _________ Tandem Walk __________

Note any abnormal movements, including upper extremity (ie: dystonic posturing, athetosis)

____ **N/A _____(16)**

SENSATION (17)

17. Sensation____ N/A ____(17)

DEEP TENDON REFLEXES (18 – 19)

18. Deep Tendon Reflexes ________________________________ N/A ______(18)

19. Babinski ________________________________ N/A ______(19)

OTHER OBSERVATIONS (20)

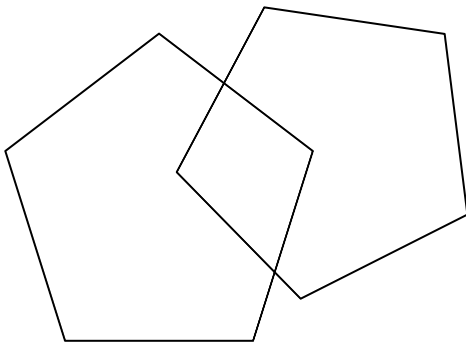
20. List any other symptoms or evidence of neurological abnormalities from history or observations.

____ **N/A ______(20)**

MENTAL STATUS EXAMINATION

MINI-MENTAL STATUS EXAM (1 - 9)

	Maximum Score	Score
1. What is the (year) (season) (date) (month)	5	_____
2. Where are we (state) (county) (city) (hospital) (floor)	5	_____
3. Name 3 objects: (e.g., cow, apple, bus) – one second to say each Then ask applicant all three after you have said them. (One point for each correct answer.) Then repeat them until he/she learns all 3. Count trials and record. Trials = ______	3	_____
4. Serial 7's. (One point for each correct.) Stop after 5 attempts	5	_____
5. Ask for the 3 objects repeated above (one point for each correct)	3	_____
6. Name a pencil and a watch	2	_____
7. Repeat: "NO IFS, ANDS, OR BUTS"	1	_____
8. Follow a 3-stage command: 'TAKE A PAPER IN YOUR RIGHT HAND. FOLD IT IN HALF, AND PUT IT ON THE FLOOR"	3	_____
9. Copy Design	1	_____



TOTAL SCORE ______

(0-21 suggests cognitive impairment) **N/A____(1-9)**

Athlete's Name:

EXAMINING NEUROLOGIST OR NEUROSURGEON

o As a licensed physician specializing in neurology or neurosurgery (circle one), I believe that this applicant could be permitted to be licensed in California.

o As a licensed physician specializing in neurology or neurosurgery (circle one), I *DO NOT* believe that this applicant could be permitted to be licensed in California.

Is further referral necessary? ______________________________

Are additional exams needed? ______________________________

I certify under penalty of perjury under the laws of the State of California that I am a licensed physician and that I specialize in neurology or neurosurgery.

______________________________ ______________________________

Licensed Neurosurgeon or Neurologist's Name *(Please Print)* Medical License Number

______________________________ ______________________________

Signature of Neurosurgeon or Neurologist Date

______________________________ ( )

(Street Address) City State Zip Phone #

The athlete is required to sign the attached authorization and acknowledgement form in either English or Spanish.

APPLICANT:

Please cooperate with the California State Athletic Commission to the fullest extent possible in making any medical history available.

The California State Athletic Commission is a public health authority, as defined in 45 CFR 164.501, exempt from HIPAA, and is authorized by Business and Professions Code Section 18600, et seq to collect information about the applicant's physical condition.

I AUTHORIZE the California State Athletic Commission under subdivision (b) of Section 1798.24 of the Civil Code to RELEASE any medical information or other personal information with respect to my status and licensure as a professional athlete which may be contained in any of its records to law enforcement agencies, physicians, or Athletic Commissions of other jurisdictions which have a need to know the information requested as determined by the commission.

______________________________ ______________________________

Printed Name of Athlete Date

____

Signature of Athlete

NEUROLOGICAL EXAMINATION ACKNOWLEDGEMENT

This examination is required for licensure and renewal of licensure of every professional athlete in the State of California.

I understand:

1. That the purpose of this screening examination is to detect possible early neurological changes resulting from cumulative head trauma which occur over extended periods of time and also changes that may affect my ability to engage in a professional boxing and/or martial arts match. This examination may uncover neurological findings that might hinder my ability to defend myself in a professional boxing and/or martial arts match.

2. That this examination does not predict possible future changes such as dementia, language difficulties, and problems with movement and coordination. Nor does it rule out the possibility of acute head trauma, such as subdural hematoma.

3. That this examination does not take the place of the general physical examination or diagnosis or medical treatment necessary for my general health or for any physical or mental condition I may otherwise have.

4. That the physician who is conducting this examination is not my personal physician and is not providing medical services to me.

5. That the results of this examination will be forwarded to the California State Athletic Commission for those purposes.

6. That any additional examinations, diagnostic procedures or treatment, including those which may be necessary for licensure as determined by the commission for the diagnosis and treatment of any physical or mental condition I may have, will only be done at my request and at my expense.

I have read and understand the statements made above.

______________________________ Signature of Athlete

____________________ Date

Attention: Applicant

When completed, please mail ALL license application requirements to:

California State Athletic Commission
2005 Evergreen Street, Suite 2010
Sacramento, CA 95825

Authority to provide the Athletic Commission with information requested on this examination is established pursuant to Section 18640, 18642, 18643, 18660, and 18711 of the California Business and Professions Code. All information is mandatory for licensure. Failure to provide this mandatory information will result in denial of a license.

Office Use

Approved By: ____________________

Date: ____________________

California State Athletic Commission
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Sacramento, CA 95815
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(916) 263-2195 FAX (916) 263-2197

PROFESSIONAL ATHLETE OPHTHALMOLOGIC EXAMINATION

***Only** a licensed physician who specializes in Ophthalmology may conduct this examination and complete this form. Please complete this form in its entirety.*

BOXING **MIXED MARTIAL ARTS** **KICKBOXING**

Office Use
Approved by: ______
Date: ______________

____
First **Middle** **Last** **Telephone** **Date of Birth**

____
Address **City** **State** **Zip Code** **Country**

HISTORY – Please provide the following information:
Has applicant ever had any of the following conditions:
1. Blurred vision? **Yes** **No**
2. Surgical procedures done to his/her eye(s) or the tissues around the eye other than simple sutures of the skin around the eye? **Yes** **No**
3. Has applicant had or been informed by a physician that he/she had significant eye problems such as retinal detachment, retinal tear, primary or secondary glaucoma, aphakia, pseudophakia, dislocated lens, or cataract? **Yes** **No** If yes, please explain:______________________________
4. Eye Disease? **Yes** **No** List nature of diseases or injuries:______________________________
5. Eye Injury? **Yes** **No** List nature of diseases or injuries:______________________________
6. Retinal re-attachment? **Yes** **No** If yes, please explain: ______________________________
7. Does the applicant have any other visual condition that would prevent him/her from safely engaging in boxing or martial arts activities? **Yes** **No** If yes, please explain: ______________________________

EXAMINATION

VISION: Without / With Glasses
Right ____________/____________
Left ____________/____________
Remarks: ______________________
____
____
____

REFRACTION: If either eye is 20/60 or worse:
Right ______ Sph_____ Cyl x_________ Acuity__________
Left ______ Sph_____ Cyl x_________ Acuity__________
Intraoccular Right_______________mmHg
Tension Left ________________mmHg
Motility Normal _______ Abnormal ______
Binocular Vision Normal _______ Abnormal ______

SLIT LAMP EXAM	**NORMAL**	**ABNORMAL**	**SPECIFY ABNORMALITIES**
Conjunctiva	Right/Left	Right/Left	
Cornea______________	_____/______	______/______	______________________________
Iris/Pupil_____________	_____/______	______/______	______________________________
Lens________________	_____/______	______/______	______________________________
Eyelids_______________	_____/______	______/______	______________________________

ATHLETE OPHTHALMOLOGIC EXAMINATION

APPLICANT NAME: ______________________________________

INDIRECT OPHTHALMOSCOPY WITH SCLERAL DEPRESSION (Dilated Pupil)

	NORMAL Right/Left	ABNORMAL Right/Left	SPECIFY ABNORMALITIES
Disc _______________	_____/______	______/______	___________________________________
Macula _______________	_____/______	______/______	___________________________________
Lens_________________	_____/______	______/______	___________________________________
Peripheral Retina ____________	_____/______	______/______	___________________________________

Title 4, Rules and Regulations, §282 states: The commission **shall** deny, suspend, revoke, or place restrictions on the license of a professional or amateur boxer or martial arts fighter because of a medical or visual condition, including but not limited to one of the following:

1) Uncorrected visual acuity of less than 20/200 in either eye or 20/60 with both eyes;
2) Corrected visual acuity of less than 20/60 in either eye, regardless of its cause;
3) A visual field of 60 degrees or less extending over one or more quadrants of the visual field;
4) Presence or history of retinal detachment or retinal tear unless treated by an ophthalmologist and then approved by an ophthalmologist specified by the commission who then assesses that the boxer is at no significant risk of further injury to the retina if boxing is resumed. Such assessment shall occur both within five days before and five days after the contest;
5) Presence of primary or secondary glaucoma, whether or not such condition has been treated;
6) Presence of aphakia, pseudophakia, dislocated lens or cataract in either eye;
7) Any other visual condition which the commission determines would prevent the applicant or licensee from safely engaging in boxing activities.

Examining physician: Any of the above conditions **MUST** be reported immediately to the Commission. **DO NOT** clear the applicant to compete if the applicant has one or more of the above symptoms. Please immediately forward a copy of any report, directly to the commission, for any applicant who has a condition that may preclude him/her from being licensed.

PHYSICIAN STATEMENT: I have read the above criteria and, in accordance with the vision requirements as stated therein, have examined the applicant named on the other side of this form.

PHYSICIAN'S REMARKS: ____

____

Based on your personal observation and review of the test results and considering Commission Rule 282 above, 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 NUMBER**

____

ADDRESS **CITY** **STATE** **ZIP CODE**

______________________________________ ______________________________________

TELEPHONE NUMBER **DATE/TIME**

____

PHYSICIAN'S SIGNATURE

December 2007-10

California State Athletic Commission
2005 Evergreen St. Ste. 2010
Sacramento, CA 95815
www.dca.ca.gov/csac/
(916) 263-2195 FAX (916) 263-2197

MRI REVIEW SUMMARY

Only a licensed physician who specializes in neurology or neurosurgery may conduct neurological examinations and complete this form.
Please complete this form in its entirety.

This examination does not take the place of any other examination required by the Commission. It also does not take the place of any general physical examination, diagnosis, or medical treatment of the applicant. It is solely for the purpose of aiding the CSAC in determining the *neurological condition of* the applicant and if he or she is fit to be licensed to compete in combative sports.

Only MRI scans conducted on a (at a minimum) 1.5 Tesla MR Machine are acceptable. The machine must be equipped with capabilities that include fast spin echo and FLAIR imaging. Image sequences should include axial T1, T2, and FLAIR images; coronal images should be performed as a T2 coronal; and a single sagittal T1 sequence.

Only diagnostic reports that are performed on machines with these specifications are accepted by the Commission. If the examination was not conducted on a machine that meets these specifications, do not complete this form.

____

Name of applicant (Print Name) **Date of Birth**

Date of MRI Diagnostic Report: ____________________ Date of this report: ______________________

Is the MRI examination within normal limits? **Yes** **No** If NO, please explain: ______________________________

____

____

Is further referral or additional examinations necessary or recommended? **Yes** **No** If yes, please explain: ____________

____

____

NOTICE TO PHYSICIAN: No clearance may be given by you to any applicant who has signs of or has suffered cerebral hemorrhage or any other serious head injury. Any such signs or observations must be reported to the Commission immediately. You may not clear an applicant to compete that demonstrates these signs or symptoms unless so instructed by the Commission.

Based on your personal medical opinion and considering Commission rules, is this applicant neurologically eligible to be licensed to compete and participate in combative sports? **Yes** **No** If no, please explain: ________________

____

EXAMINING PHYSICIAN INFORMATION:

_______________________________ _______________________________

LICENSED PHYSICIAN'S NAME (print) **MEDICAL LICENSE NUMBER**

____

ADDRESS **CITY** **STATE** **ZIP CODE**

_______________________________ _______________________________

TELEPHONE NUMBER **DATE/TIME**

____

PHYSICIAN'S SIGNATURE

NEUROLOGICAL EXAMINATION ACKNOWLEDGEMENT

This examination is required for licensure and renewal of licensure of every professional athlete in the State of California.

I understand:

1. That the purpose of this screening examination is to detect possible early neurological changes resulting from cumulative head trauma which occur over extended periods of time and also changes that may affect my ability to engage in a professional boxing and/or martial arts match. This examination may uncover neurological findings that might hinder my ability to defend myself in a professional boxing and/or martial arts match.

2. That this examination does not predict possible future changes such as dementia, language difficulties, and problems with movement and coordination. Nor does it rule out the possibility of acute head trauma, such as subdural hematoma.

3. That this examination does not take the place of the general physical examination or diagnosis or medical treatment necessary for my general health or for any physical or mental condition I may otherwise have.

4. That the physician who is conducting this examination is not my personal physician and is not providing medical services to me.

5. That the results of this examination will be forwarded to the California State Athletic Commission for those purposes.

6. That any additional examinations, diagnostic procedures or treatment, including those which may be necessary for licensure as determined by the commission for the diagnosis and treatment of any physical or mental condition I may have, will only be done at my request and at my expense.

I have read and understand the statements made above.

______________________________ Signature of Athlete

______________________________ Date

Attention: Applicant

When completed, please mail ALL license application requirements to:

California State Athletic Commission
2005 Evergreen St., Suite 2010
Sacramento, CA 95815

Authority to provide the Athletic Commission with information requested on this examination is established pursuant to Section 18640, 18642, 18643, 18660, and 18711 of the California Business and Professions Code. All information is mandatory for licensure. Failure to provide this mandatory information will result in denial of a license.

Office Use

Approved By: ____________________________

Date: ________________________________

California State Athletic Commission
2005 Evergreen St. Ste. 2010
Sacramento, CA 95815
www.dca.ca.gov/csac/
(916) 263-2195 FAX (916) 263-2197

CARDIOVASCULAR HISTORY

BOXING **MIXED MARTIAL ARTS** **KICKBOXING**

Only a licensed physician may conduct
Physical and EKG examinations and complete this form.
Please complete this form in its entirety.

This examination does not take the place of any other examination required by the Commission. It also does not take the place of any general physical examination, diagnosis, or medical treatment of the applicant. It is solely for the purpose of aiding the CSAC in determining whether the whether the applicant's present *cardiac condition* permits him or her to be licensed for competition.

____

Name of applicant (Print Name) **Date of Birth**

Date of EKG Report: ____________________ Date of this report: ______________________

Have you ever fainted during or after exercise? **Yes** **No** If YES, please explain: ______________
____

How many bouts have you had since your last EKG? **Yes** **No** If YES, please explain: __________
____

How many rounds have you fought since your last EKG? **Yes** **No** If YES, please explain: ________
____

Have you ever had chest pain during or after exercise? **Yes** **No** If YES, please explain: _________
____

Do you get tired more quickly than your friends do during exercise? **Yes** **No** If YES, please explain:
____

Have you ever had racing of your heart or skipped heartbeats? **Yes** **No** If YES, please explain:
____

Have you been told you had high blood pressure or high cholesterol? **Yes** **No** If YES, please explain: ____

Have you ever been told you have a heart murmur? **Yes** **No** If YES, please explain: ____________
____

Has any family member or relative died of heart problems or of sudden death before age 50? **Yes** **No**
If YES, please explain: ____

CARDIOVASCULAR HISTORY

APPLICANT NAME: ____

Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the past month?
Yes **No** If YES, please explain: ____

Has a physician ever denied or restricted your participation in sports for any heart problems? **Yes** **No**
If YES, please explain: ____

Does the athlete have Normal Sinus Rhythm? **Yes** **No** If NO, please explain: ___________________
____

IS THE EKG REPORT WITHIN NORMAL LIMITS? **Yes** **No** If NO, please explain:_____________
____

Based on your personal medical opinion and considering Commission rules, is this applicant cardiologically eligible to be licensed to compete and participate in combative sports? **Yes** **No**
If no, please explain: ____
____

Is further referral or additional examinations necessary or recommended? **Yes** **No** If yes, please explain:____
____

EXAMINING PHYSICIAN INFORMATION:

_______________________________________ _______________________________________
LICENSED PHYSICIAN'S NAME (print) **MEDICAL LICENSE NUMBER**

____
ADDRESS **CITY** **STATE** **ZIP CODE**

_______________________________ _______________________________________
TELEPHONE NUMBER **DATE/TIME**

____
PHYSICIAN'S SIGNATURE

OFFICE USE ONLY

Approved by: ________________

Date: ______________

December 2007-08

California State Athletic Commission
2005 Evergreen St., Ste. 2010
Sacramento, CA 95815
www.dca.ca.gov/csac/
(916) 263-2195 FAX (916) 263-2197

Authorization to Use and Disclose Protected Health Information

The California State Athletic Commission is a public health authority, as defined in 45 CFR 164.501, exempt from HIPAA, and is authorized by California Business and Professions Code Sections 18600 et seq. to collection information about the applicant's mental and physical health.

I hereby authorize my personal physicians and other healthcare providers and all hospitals or similar institutions or organizations to furnish to the California State Athletic Commission or its successors copies of all my medical records, hospital records, records of treatment for drug and/or alcohol abuse or dependency, or other information requested by that Commission in connection with this application or any further or future investigation by that Commission necessary to determine my fitness for licensure.

I further authorize the Commission or its successors to release any medical or other personal information with respect to my application or licensure to the organizations, individuals or groups listed above and to other regulatory bodies. The Commission will release this information only to those athletic commissions (or similar regulatory bodies) that have a need to know, as determined by the Commission. This disclosure of records is required for official use, including investigation of my fitness for licensure by the Commission. I understand that the recipient of my information is not a health plan or health care provider and the released information may no longer be protected by federal privacy regulations.

I understand that I have a right to receive a copy of this authorization if I request it. I may inspect or obtain a copy of the protected health information that I am being asked to disclose.

I understand that I have a right to revoke this authorization by sending written notification to the California State Athletic Commission, 2005 Evergreen St., Suite 2010, Sacramento, California 95815. I understand that if I revoke this authorization, I may not be allowed to continue in the licensure process, or, if I am licensed, my license may be adversely affected.

This authorization shall remain valid for one year from the date a license is issued to me. A copy of this authorization shall be as valid as the original.

Applicant:

____ **Date:** ____________________

Name **Signature**

California State Athletic Commission
2005 Evergreen St. Ste. 2010
Sacramento, CA 95815
www.dca.ca.gov/csac/
(916) 263-2195 FAX (916) 263-2197

PRE-BOUT MEDICAL QUESTIONNAIRE

This questionnaire needs to be completed in full. Only the licensed Commission Physician evaluating the contestant may assist the contestant in completing this questionnaire.

Attention Physician:

All available licensing medical examinations and competition history are in the Event Package. At a minimum the medical examinations available to you there are the MRI Diagnostic Report, Physical Examination, EKG Report, Neurological Examination, Ophthalmologic Examination and lab work. Please consult with the Event Supervisor if you need any additional information or if there is information missing.

If any condition is disclosed in this questionnaire, you shall immediately inform the Commission Representative and unless a clearance is received from the contestant's attending physician in consultation with you or a Commission approved physician, the contestant will not be allowed to compete.

You must be able to determine that the specific condition and or matter in question does not affect the contestant's ability to perform or present a potential threat to the contestant's health as a result of competing in the contest or match.

Contestant's Name: ____

Personal physician contact information:

Name:______________________________ Telephone number: ______________________

When was your last bout, and what was the result of the bout? ______________________________

How much did you weigh when you began training for this bout? ____________ Two weeks ago? ____________

Have you ever suffered any knockouts (KO's), technical knockout's (TKO's), or any kind of loss of consciousness in the last twelve (12) months during a bout, sparring or in any other activity? ☐ **YES** ☐ **NO** If yes, please list and give dates and details:

____

Have you ever had any broken bones or arthritis? ☐ **YES** ☐ **NO** If yes, please give date and the details: ____________

____

Have you ever suffered any eye injury or had any eye problems? ☐ **YES** ☐ **NO** If yes, please list and give dates and details:

____

Have you ever had any hearing problems? ☐ **YES** ☐ **NO** If yes, please give date and the details: ______________

____

Have you ever had a neuromuscular condition, including peripheral nerves, muscle or brain problems? ☐ **YES** ☐ **NO** If yes, please give date and details: ____

Have you ever had any heart or cardiovascular condition? ☐ **YES** ☐ **NO** If yes, please give date and details: ____________

____

Have you ever had any pulmonary or respiratory condition including asthma? ☐ **YES** ☐ **NO** If yes, please give details:

____

Are you pregnant? ☐ **YES** ☐ **NO** If yes, please give date the pregnancy was confirmed and refer to the Pregnancy Advisory Notice: ____

PRE-BOUT MEDICAL QUESTIONNAIRE

Applicant Name: ____________________________________

Have you ever had any renal or urological condition? ☐ **YES** ☐ **NO** If yes, please give date and details: _________________

____

Have you ever had a hematological condition or any unusual bleeding or bruising problems? ☐ **YES** ☐ **NO** If yes, please give date and details: ____

Do you have any conditions of which you are aware such as:

Any surgical procedure? ☐ **YES** ☐ **NO** If yes, please list and give dates and details: _____________________________

Any serious illness, disease or allergy from either food or medicine? ☐ **YES** ☐ **NO** If yes, please give date and details:

____

Any lacerations (cuts) requiring sutures in the last 90 days? ☐ **YES** ☐ **NO** If yes, please list and give dates and details:

____

To your knowledge have you taken any of the following:

Any medication or drug either over the counter or prescribed ☐ **YES** ☐ **NO** If yes, please list and give dates and details: ____

Any medication, drug or vitamin supplement to help you lose weight for this bout ☐ **YES** ☐ **NO** If yes, please list and give dates and details: ____

Any vitamin or nutritional supplement ☐ **YES** ☐ **NO** If yes, please list and give dates and details:

____

Have you undergone any of the following medical examinations:

MRI or CT scan of the brain? (Brain imaging scan)? ☐ **YES** ☐ **NO** If yes, please list and give dates and details:

____

EEG (Test that measures electrical activity in the brain)? ☐ **YES** ☐ **NO** If yes, please list and give dates and details:

____

EKG (Test that measures electrical activity of the heart)? ☐ **YES** ☐ **NO** If yes, please give date and details:

____

I, ____,

PRINT NAME / SIGNATURE

the CONTESTANT, declare under penalty of perjury under the laws of the State of California, that the foregoing information is true and correct; further I realize that any intentional misrepresentation may result in disciplinary action against my license.

I, ____,

PRINT NAME / SIGNATURE

assisted the Contestant in completing this form and declare under penalty of perjury under the laws of the State of California, that the foregoing information is true and correct; further I realize that any intentional misrepresentation may result in disciplinary action against my license.

COMMISSION PHYSICIAN CONDUCTING THIS EVALUATION:

____ ____

NAME (print) **SIGNATURE**

DATE:_____________________________________ **TIME:**_____________________________________

California State Athletic Commission
2005 Evergreen St. Ste. 2010
Sacramento, CA 95815
www.dca.ca.gov/csac/
(916) 263-2195 FAX (916) 263-2197

Pregnancy Advisory Notice

ALERT: If you participate in combative sports when you are pregnant you could have a miscarriage or you and or your fetus could suffer permanent injury or death

The Commission cannot require you to have a pregnancy test as a requirement for licensing or before a bout. However, it strongly urges you to be tested before each of your bouts.

<u>The Commission strongly urges you to not compete if you know or think you may be pregnant.</u>

Through this notice the Commission informs you that the State of California or any of its agents and the physician who conducts your pre-bout examination(s) is not responsible for any injury that you and or your fetus suffers if you compete when you are pregnant.

* * * *

By signing below, I acknowledge receipt of this notice.

Participant:

____

Name Signature Date

Commission Representative:

____

Name Signature Date