STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR

CALIFORNIA STATE ATHLETIC COMMISSION
2005 Evergreen Street, Suite 2010 | Sacramento, California 95815
Phone: (916) 263-2195 Fax: (916) 263-2197
Website: www.dca.ca.gov/csac Email: CSAC@dca.ca.gov

REFEREE ANNUAL PHYSICAL EXAMINATION REPORT

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

APPLICANT NAME **DATE OF BIRTH** **TELEPHONE NUMBER**

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

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

☐ Fainting spells ☐ Rupture (hernia) ☐ Chest pains ☐ Operations ☐ Shortness of breath
☐ Swollen joints ☐ Rheumatism ☐ Diabetes ☐ Frequent headaches
☐ Convulsions (fits) ☐ Chronic cough ☐ None ☐ Spitting of blood
☐ Cerebral hemorrhage or serious head injury

Has the applicant ever been a patient in a mental hospital? ☐ Yes ☐ No If yes, explain:

_____

_____

Other hospitalizations? ☐ Yes ☐ No If yes, explain:

_____

_____

Is the applicant under any type of prescription medication(s) that may diminish his or her skills to officiate? If so, please explain and forward any and all medical records related to the drug being prescribed. If the applicant is under prescription medication relevant medical records must be forwarded to the commission for review prior to the granting or renewal of a license. Please state your opinion whether the applicant is or is not suitable to officiate while under the prescribed medication(s).

_____

_____

_____

_____

PHYSICAL EXAMINATION:

General appearance: _____ Height: _____ Weight: _____

Is the applicant's weight proportionate to height in accordance with standards of the AMA and or pursuant to Rule 371?
☐ Yes ☐ No If No, please state if this will preclude the applicant from officiating. _____

_____

Temperature: _____ Disabling scars: _____ Mouth: _____ Teeth: _____ Neck: _____
Tonsils: _____ 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
Apical impulse ☐ Heavy ☐ Normal Enlargement ☐ Yes ☐ No Murmurs ☐ Yes ☐ No Lungs: Rales ☐ Yes ☐ No
Abdomen: Enlargement of liver ☐ Yes ☐ No Enlargement of Spleen: ☐ Yes ☐ No Hernia: ☐ Yes ☐ No
Femoral: ☐ Inguinal ☐ Ventral
Reflexes: Pupils _____ Knee jerks _____ Romberg _____ Babinski _____
Skin: Tone _____ Rash _____ Boils _____ Unhealed wounds: _____

REMARKS: _____

_____

_____

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APPLICANT NAME: _____

EYE HISTORY: Has the applicant ever had blurred vision? ☐ Yes ☐ No If YES, please explain:

_____

_____

Has the applicant ever had any surgical procedures done to the eye(s)? ☐ Yes ☐ No If Yes, please explain:

_____

_____

EYE EXAMINATION:

Does the applicant wear eyeglasses? ☐ Yes ☐ No **Contact lenses? ☐ Yes ☐ No**

Vision without glasses/contact lenses: Right _____ Left _____

Vision with glasses: Right _____ Left _____

Vision with contact lenses: Right _____ Left _____

(Applicant must have uncorrected visual acuity of at least 20/100 in both eyes pursuant to Athletic Commission Rule 371.)

I have examined the above named applicant and I ☐ DO FIND ☐ DO NOT FIND this person to be physically and or mentally fit; in good physical condition with the speed and reflexes necessary for the protection of athletes during competition.

I ☐ DO FIND ☐ DO NOT FIND a condition that would preclude him/her from being licensed as a referee.

I (physician), *declare under penalty of perjury* under the laws of the State of California, that the above named subject's physical condition is correctly outlined in this REPORT OF PHYSICAL EXAMINATION FOR REFEREES. I declare that I prepared this form. I realize that any intentional misrepresentation may result in the California State Athletic Commission's reporting to the State of California Medical Board and that disciplinary action against my license may be applied.

_____ _____

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

_____

STREET ADDRESS **CITY** **STATE** **ZIP CODE** **PHONE NUMBER**

_____ _____

PHYSICIAN'S SIGNATURE **DATE/TIME OF EXAMINATION**

REFEREE ANNUAL PHYSICAL EXAMINATION REPORT

APPLICANT NAME: _____

Authorization to Use and Disclose Protected Health Information

The California State Athletic Commission (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 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 Athletic 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 Athletic Commission will release this information only to those athletic commissions (or similar regulatory bodies) that have a need to know, as determined by the Athletic Commission. This disclosure of records is required for official use, including investigation of my fitness for licensure by the Athletic 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 Street, 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.

_____

Name of Applicant

_____ _____

Signature of Applicant **Date**

Office Use
Approved by: _____
Date: _____
Exp. Date: _____