ARIZONA BOXING AND MIXED MARTIAL ARTS COMMISSION

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PHYSICAL EXAMINATION FOR UNARMED COMBATANT

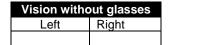
Applicant Phone: ()							
APPLICANT INFORMA	TION						
🗆 MALE 🗆 FEMAL							
Applicant Last Name First Name		Date of Birth					
Street Address City	State	Zip					
PHYSICAL HISTORY							
Has applicant had any of the following conditions: Fainting spells Rupture (hernia) Shortness of breath Swollen joints Frequent head aches Convulsions (fits) Spitting blood Cerebral hemorrhage or any other	Chest pain Rheumatism Chronic cough	OperationsDiabetesBleeding disorder					
Number of knockouts received Date of last knockout Longest duration of unconsciousness Have you ever been knocked unconscious in any other sport or in any other way? If yes, explain:							
BOXING / UNARMED COMB	AT RECORD						
Pro Boxing Wins Losses Draws Pro MMA Wins Losses Draws Amateur MMA Wins Losses Draws							
PHYSICAL EXAMINA							
General appearance Height Disabling scars Mouth Pulse at rest Blood pressure at rest Pulse after 100 hops Blood pressure after 100 hops Blood pressure 2 minutes later	Weight Te	emperature Neck					
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							
	Discharge □ Yes □ No een □ Yes □ No een □ Yes □ No)					
Pelvic: Normal Q Yes Q No Remarks:							
Reflexes: Pupils Knee jerks Romberg Skin: Rash Boils Any other unhealed Speech: Slurred? Yes No Other:	Babinski wounds:						
General issues (memory, judgment):							

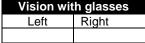
EYE HISTORY

Has applicant every had any of the following conditions:

- 1. Blurred vision? ☐ Yes ☐ No
- 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 ever been informed by a physician that he/she had significant eye problems such as retinal detachment, retinal tear, primary or secondary glaucoma, aphakia, pseudophakia lens? \Box Yes \Box No

EYE EXAMINATION





Visual Field					
Left	Right				

SEROLOGY

THE ORIGINAL REQUIRED LAB REPORT WITH APPLICANT'S NAME AND DATE THE TEST WAS PERFORMED <u>MUST</u> BE SUBMITTED.

REQUIRED LAB REPORTS TO INCLUDE: HIV, Hepatitis B (Surface Antigen) and Hepatitis C (Antibody)

EXAMINING PHYSICIAN (MUST BE AN MD OR DO PHYSICIAN)

I have examined the above named subject and I
HAVE HAVE NOT medically cleared to fight.

Remarks:						
PHYSICIAN'S NAME	/ LICENSE #	(PLEASE PR	INT)	Ş	SIGNATURE BY (MD or DO) ONLY	DATE
OFFICE NAME						
STREET ADDRESS						
					()	
CITY	ST	λTE	ZIP CODE		PHONE NUMBER	
\/						-
MEDICAL RELEASE AUTHORIZATION BY APPLICANT						

I AUTHORIZE any physician to release to the Arizona Boxing and MMA Commission any of my medical records in his/her possession. I also authorize the Arizona Boxing and MMA Commission to release any medical information or other personal information with respect to my status and licensure as a professional boxer or unarmed combatant which may be contained in any of its records to other State Commissions. I agree that a photographic copy of this authorization shall be valid as the original. I agree that this authorization will be valid for a period of one year from the date indicated in this document.

NAME OF APPLICANT (PLEASE PRINT)

APPLICANT'S SIGNATURE

DATE

ARIZONA BOXING AND MIXED MARTIAL ARTS COMMISSION

DILATED EYE EXAM REPORT OF EYE EXAMINATION FOR PROFESSIONAL BOXER / UNARMED COMBATANT TO BE PERFORMED BY AN <u>OPTOMETRIST OR OPHTHALMOLOGIST</u>								
Last Name	F	irst Name		I	Middle		Date of Birth	
Street Address			_ City			State	Zip	
	Boxing Record:			FIGHTER:	MMA Re	cord:		
HISTORY If possible provide the following information: Name and hometown of physician in charge: 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 ever 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:								
			XAMINA	TION				
VISION:	Without With Glasses	REFRAC	TION: If eith	ner eye is 20/	/40 or wor	se:		
Right Left		Right Left		Sph Sph		Cylx Cylx	Acuity Acuity	
Intraocular Tension Motility Binocular Vision	Right Left Normal Normal	Abnormal Abnormal	mml	Чg		<u> </u>		
	LAMP EXAM	NOR Right	MAL Left	ABN0 Right	DRMAL Left	SP	ECIFIC ABNORMALITI	ES
Conjunctiva Cornea Iris/Pupil Lens Eyelids								
INDIRECT OPH Disc Macula Vessels Peripheral Retin	ITHALMOSCOPY WI	TH SCLERAL DEPR NOR Right			DRMAL Left	SP	ECIFIC ABNORMALITI	ES

100 N. 15th Ave., Suite 202 Phoenix, Arizona 85007 Phone: (602) 364-1721 Fax: (602) 255-3883 Website: https://boxingandmma.az.gov

DILATED EYE EXAM PAGE 2

The Commission shall deny, suspend, revoke, or place restrictions on the license of a professional boxer or martial arts fighter because of a medical or visual condition, (The Commission may also place restrictions for the same medical conditions on all amateur combatants under its jurisdiction) including but not limited to 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.

The examining physician is requested to mail or fax a copy of any report, directly to the Commission of an applicant that has a condition that may preclude him/her from being licensed or cleared to participate in any combat activities.

REPORT OF EYE EXAMINATION FOR PROFESSIONAL BOXER / UNARMED COMBATANT

OPTOMETRIST OR OPHTHALMOLOGIST MUST COMPLETE ALL ITEMS LISTED BELOW

I have read the above criteria and, in accordance with the vision requirements as stated therein, have examined the applicant named on page 1 and page 2 of this form and

I HAVE HAVE NOT medically cleared him/her to compete as a licensed boxer/unarmed combatant.

PHYSICIAN NAME	/	LICENSE #	(please print)	PHYSICIAN SIGNATURE
OFFICE NAME AND STREET AD	DRI	ESS		DATE
CITY		STATE	ZIP CODE	() PHONE NUMBER

* MEDICAL RELEASE AUTHORIZATION BY APPLICANT

I AUTHORIZE any physician to release to the Arizona Boxing and MMA Commission any of my medical records in his/her possession. I also authorize the Arizona Boxing and MMA Commission to release any medical information or other personal information with respect to my status and licensure as a professional boxer or unarmed combatant which may be contained in any of its records to other State Commissions. I agree that a photographic copy of this authorization shall be valid as the original. I agree that this authorization will be valid for a period of one year from the date indicated in this document.

SIGNATURE OF APPLICANT

DATE	-	

NAME PRINTED

PHONE NUMBER

ANY ATTEMPT TO ALTER OR FALSIFY THIS DOCUMENT WILL RESULT IN FORFIETURE OF LICENSE AND/OR PROSECUTION IN A CRIMINAL COURT OF LAW.