DEPARTMENT OF CONSUMER AFFAIRS
BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR
CALIFORNIA STATE ATHLETIC COMMISSION
2005 Evergreen Street, Suite 2010 | Sacramento, CA 95815
Phone: (916) 263-2195 | Fax: (916) 263-2197
Website: www.dca.ca.gov/csac | Email: csac@dca.ca.gov

AMATEUR ATHLETE PHYSICAL EXAMINATION
KICKBOXING

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

NOTE TO PHYSICIAN: PLEASE EMAIL COMPLETED FORM TO csac@dca.ca.gov OR FAX TO (916) 263-2197.

Last Name **First Name** **Middle Name**

Address:

Street (No PO BOX) **City** **State** **Zip Code** **Country**

Telephone number: **Email:**

Male / Female (circle one)	**Age:**	**Date of Birth: (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 Mixed Martial Arts Record:

Wins: _____ Wins by KO/TKO/Submissions: _____

Losses: _____ Losses by KO/TKO/Submissions: _____

Amateur Mixed Martial Arts Record:

Wins: _____ Wins by KO/TKO/Submissions: _____

Losses: _____ Losses by KO/TKO/Submissions: _____

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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 (circle one) **Regular** **Irregular**
Murmurs: ☐ **Yes** ☐ **No** Musculoskeletal system: _____
Apical impulse (circle one): **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: _____
_____

The information contained on this form is maintained by the Executive Officer of the California State Athletic Commission, 2005 Evergreen St, Ste #2010, Sacramento, CA 95815, (916) 263-2195. All items of information are mandatory; none are voluntary. Failure to provide any of the requested information will delay the processing of your application or result in your application being rejected as incomplete. The information provided will be used to determine your qualifications for licensure pursuant to Business and Professions Code Section 18640. The information on your application may be transferred to other governmental or law enforcement agencies. You have the right to review records maintained on you by the Athletic Commission unless the records are identified as confidential information pursuant to the Public Records Act or are exempted by Section 1798.40 of the Civil Code. You may gain access to the information by contacting the Athletic Commission at the address above.

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

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