



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



CARDIOVASCULAR HISTORY

*Only a licensed physician may conduct EKG examinations 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.

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 Commission in determining whether the applicant's present *cardiac condition* permits him or her to be licensed for competition.

Name of applicant (Print Full 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? _____

How many rounds have you fought since your last EKG? _____

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: _____

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: _____

CARDIOVASCULAR HISTORY

APPLICANT NAME: _____

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: _____

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