



CALIFORNIA STATE ATHLETIC COMMISSION

2005 Evergreen Street, Suite 2010 | Sacramento, California 95815

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Website: www.dca.ca.gov/csac Email: CSAC@dca.ca.gov



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.

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 California State Athletic Commission (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 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, FLAIR images and gradient echo axial; 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 Full 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: _____

_____ 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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