

ARIZONA BOXING AND MIXED MARTIAL ARTS COMMISSION

PHYSICAL EXAM

PHYSICAL EXAMINATION FOR UNARMED COMBATANT

Applicant Phone: (____)____-_____

APPLICANT INFORMATION

MALE FEMALE

Applicant Last Name _____ First Name _____ Middle _____ Date of Birth _____

Street Address _____ City _____ State _____ Zip _____

PHYSICAL HISTORY

Has applicant had any of the following conditions:

- | | | | |
|----------------------------------------------|--------------------------------------------------------------------------|----------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Rupture (hernia) | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Operations |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Swollen joints | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Frequent head aches | <input type="checkbox"/> Convulsions (fits) | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Bleeding disorder |
| <input type="checkbox"/> Spitting blood | <input type="checkbox"/> Cerebral hemorrhage or any other serious injury | | |

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? Yes No

If yes, explain: _____

BOXING / UNARMED COMBAT RECORD

Pro Boxing	Wins _____	Losses _____	Draws _____
Pro MMA	Wins _____	Losses _____	Draws _____
Amateur MMA	Wins _____	Losses _____	Draws _____

PHYSICAL EXAMINATION

General appearance _____ Height _____ Weight _____ Temperature _____

Disabling scars _____ Mouth _____ Teeth _____ Tonsils _____ Neck _____

Pulse at rest _____ Blood pressure at rest _____

Pulse after 100 hops _____ Blood pressure after 100 hops _____

Blood pressure 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

Breasts: Mass Yes No Tenderness Yes No Discharge Yes No

Abdomen: Enlargement of liver Yes No Enlargement of spleen Yes No

Hernia Yes No Enlargement of spleen Yes No

Testicles: Normal Yes No Remarks: _____

Pelvic: Normal Yes No Remarks: _____

Reflexes: Pupils _____ Knee jerks _____ Romberg _____ Babinski _____

Skin: Rash _____ Boils _____ Any other unhealed wounds: _____

Speech: Slurred? Yes No Other: _____

General issues (memory, judgment): _____

Remarks: _____

1110 West Washington, Suite 450
Phoenix, Arizona 85007

Phone: (602) 364-1721 Fax: (602) 255-3883

Website: <https://boxingandmma.az.gov>

PHYSICAL EXAMINATION

EYE HISTORY

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 lens? Yes No

EYE EXAMINATION

Vision without glasses	
Left	Right

Vision with glasses	
Left	Right

Visual Field	
Left	Right

SEROLOGY

THE ORIGINAL REQUIRED LAB REPORT WITH APPLICANT'S NAME AND DATE THE TEST WAS PERFORMED **MUST 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 PRINT) SIGNATURE BY (MD or DO) ONLY DATE

OFFICE NAME

STREET ADDRESS

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.

NAME OF APPLICANT (PLEASE PRINT) APPLICANT'S SIGNATURE DATE

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ARIZONA BOXING AND MIXED MARTIAL ARTS COMMISSION

DILATED EYE EXAM

REPORT OF EYE EXAMINATION FOR PROFESSIONAL BOXER / UNARMED COMBATANT TO BE PERFORMED BY AN OPTOMETRIST OR OPHTHALMOLOGIST

Last Name _____ First Name _____ Middle _____ Date of Birth _____

Street Address _____ City _____ State _____ Zip _____

BOXER Boxing Record: _____ **MMA FIGHTER:** MMA Record: _____

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: _____

4. Eye disease: Yes No List nature of disease: _____

5. Eye injury: Yes No List nature of injury: _____

6. Detached retina surgery on either eye: Yes No
List which eye and when and where surgery was done: _____

EXAMINATION

VISION:	Without	With Glasses
Right		
Left		

REFRACTION: If either eye is 20/40 or worse:							
Right		Sph		Cyl x		Acuity	
Left		Sph		Cyl x		Acuity	

Intraocular Tension Right _____ mmHg

Left _____ mmHg

Motility Normal _____ Abnormal _____

Binocular Vision Normal _____ Abnormal _____

Remarks: _____

SLIT LAMP EXAM

NORMAL

ABNORMAL

SPECIFIC ABNORMALITIES

	Right	Left	Right	Left	
Conjunctiva					
Cornea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Iris/Pupil	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eyelids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

INDIRECT OPHTHALMOSCOPY WITH SCLERAL DEPRESSION (Dilated Pupil)

NORMAL

ABNORMAL

SPECIFIC ABNORMALITIES

	Right	Left	Right	Left	
Disc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Macula	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Vessels	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Peripheral Retina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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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
PHYSICIAN REMARKS:

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 ADDRESS				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 FORFEITURE OF LICENSE AND/OR PROSECUTION IN A CRIMINAL COURT OF LAW.