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:

☐ Fainting spells	☐ Rupture (hernia)	☐ Chest pain	☐ Operations
☐ Shortness of breath	☐ Swollen joints	☐ Rheumatism	☐ Diabetes
☐ Frequent head aches	☐ Convulsions (fits)	☐ Chronic cough	☐ Bleeding disorder
☐ Spitting blood	☐ 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: ____

____

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

PHYSICAL EXAMINATION

EYE HISTORY

Has applicant every 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		Vision with glasses		Visual Field	
Left	Right	Left	Right	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**

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 Right	NORMAL Left	ABNORMAL Right	ABNORMAL Left	SPECIFIC ABNORMALITIES
Conjunctiva						
Cornea	________	☐	☐	☐	☐	________
Iris/Pupil	________	☐	☐	☐	☐	________
Lens	________	☐	☐	☐	☐	________
Eyelids	________	☐	☐	☐	☐	________

INDIRECT OPHTHALMOSCOPY WITH SCLERAL DEPRESSION (Dilated Pupil)

		NORMAL Right	NORMAL Left	ABNORMAL Right	ABNORMAL Left	SPECIFIC ABNORMALITIES
Disc	________	☐	☐	☐	☐	________
Macula	________	☐	☐	☐	☐	________
Vessels	________	☐	☐	☐	☐	________
Peripheral Retina	________	☐	☐	☐	☐	________

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