



**Combatant Application  
Handbook  
2023**

# ARIZONA BOXING AND MIXED MARTIAL ARTS COMMISSION

## UNARMED COMBATANT APPLICATION CHECKLIST

Use this checklist as a guide to complete each item before submitting your application. Take a photo of each item once complete and save it for your records. **You will upload these into your application when you get to Step 8.**

### Step 1: Bloodwork \_\_\_\_\_

You must present negative results for the following tests: HIV, Hepatitis B (**Surface Antigen**), and Hepatitis C (**Antibody**). Take a photo of the results and upload to your application.

### Step 2: Physical Exam \_\_\_\_\_

You must present evidence of a healthy physical ability. Please use the **Physical Exam Form** on Pages 1 and 2. Exam must be conducted by a licensed **M.D.** or **D.O.** Take a photo of the completed forms and upload to your application.

### Step 3: Eye Exam \_\_\_\_\_

You must present a completed Ophthalmological Exam. Please use the **Dilated Eye Exam Form** on Page 3 and 4. This step must be conducted by a licensed **Optometrist** or **Ophthalmologist**. Take a photo of the completed exam and upload to your application.

### Step 4: EKG\* \_\_\_\_\_

**OVER-AGE APPLICANTS ONLY!** Applicants 36 years of age and older must get special permission from the Commission and are required to furnish the results of a stress test administered by a licensed **M.D.** or **D.O.** These results must be accompanied by a clearance letter and the results of an electrocardiogram (EKG) that demonstrates normal cardiovascular function. Take a photo of the results and upload to your application.

### Step 5: Federal Combatant ID \_\_\_\_\_

If you do not already have a Federal ID for your sport (e.g. Boxing or MMA), you must complete the respective form in order to obtain a Federal ID. Page 5 for MMA, Page 6 for Boxing. Take a photo of the completed form and upload to your license application.

### Step 6: Identification Docs \_\_\_\_\_

A copy of the applicant's Driver's License, Valid Identification or other Lawful Presence Documents must be provided with the Arizona License Application. Take a photo of your Driver's License, Birth Certificate, or Passport and upload to your application.

### Step 7: Headshot/Selfie \_\_\_\_\_

Take a photo or selfie of yourself looking at the camera from the shoulders up and upload to your license application.

### Step 8: License Application \_\_\_\_\_

Only complete this step once all other previous steps are complete and you have photos of each document. Go to this link: <https://bit.ly/3diuX27> or scan the QR code below. You will be required to upload the above documentation into the application.



### Step 9: Payment \_\_\_\_\_

Once you have submitted your application, you must pay the licensing fee at this link: <https://adgpay.az.gov/content/boxing-mma> or scan the QR code below. Once paid, your application is complete.



# 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: \_\_\_\_\_

**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	
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

# 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:**

		Sph		Cyl x		Acuity
Right						
Left						

Intraocular Tension Right \_\_\_\_\_ mmHg

Left \_\_\_\_\_ mmHg

Motility Normal \_\_\_\_\_ Abnormal \_\_\_\_\_

Binocular Vision Normal \_\_\_\_\_ Abnormal \_\_\_\_\_

Remarks: \_\_\_\_\_

\_\_\_\_\_

#### SLIT LAMP EXAM

#### NORMAL

#### ABNORMAL

#### SPECIFIC ABNORMALITIES

Conjunctiva

Cornea \_\_\_\_\_

Iris/Pupil \_\_\_\_\_

Lens \_\_\_\_\_

Eyelids \_\_\_\_\_

Right Left

Right Left

#### INDIRECT OPHTHALMOSCOPY WITH SCLERAL DEPRESSION (Dilated Pupil)

#### NORMAL

#### ABNORMAL

#### SPECIFIC ABNORMALITIES

Disc \_\_\_\_\_

Macula \_\_\_\_\_

Vessels \_\_\_\_\_

Peripheral Retina \_\_\_\_\_

Right Left

Right Left

**DILATED EYE EXAM**

*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.**

**COLOR PHOTO**  
(Passport Type)

**ASSOCIATION OF BOXING COMMISSIONS**  
MIXED MARTIAL ARTS  
NATIONAL IDENTIFICATION CARD

**FOR OFFICIAL USE ONLY**

ID #: \_\_\_\_\_

DATE ISSUED: \_\_\_\_\_

ISSUED BY: AZ BOXING  
AND MMA COMMISSION

EXPIRES: \_\_\_\_\_

**APPLICATION FORM**

**AMATEUR**

**PROFESSIONAL**

FIRST NAME: \_\_\_\_\_ LAST NAME: \_\_\_\_\_ MIDDLE NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ SOCIAL SECURITY # ----- \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE/PROVINCE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HEIGHT: \_\_\_\_' \_\_\_\_" WEIGHT: \_\_\_\_\_ lbs. COLOR OF HAIR: \_\_\_\_\_ COLOR OF EYES: \_\_\_\_\_

HOME PHONE: (\_\_\_\_) \_\_\_\_\_ E-MAIL ADDRESS: \_\_\_\_\_

BIRTHMARKS, SCARS OR TATTOO'S: \_\_\_\_\_

(List area of body: Face, Neck, Back, Arm, Leg, etc.)

YEARS OF EXPERIENCE: \_\_\_\_\_

**TERMS AND CONDITIONS:**

1. Applicant must apply for National MMA ID Card in the state/province in which he/she is a resident.
2. National MMA ID Card, will not be issued unless an accurate and truthful application form is completed in its entirety. Incomplete forms will not be accepted and will be returned to applicant for completion.
3. Two color (passport type) photos must be submitted with the completed application form.
4. Two forms of identification must be presented at the time of application and must include a color photo of the applicant. Accepted forms of identification will include, but not be limited to driver's license, passport, state/province issued identification or any other form of identification accepted by issuing Commission.
5. Applicant understands that he/she will not be allowed to compete without a National MMA ID Card.
6. Applicant understands that the ABC in cooperation with the issuing Commission will settle any and all disputes with regards to violations of these terms and conditions for the National MMA ID Card. The ruling of the ABC is final and binding on all parties.
7. Applicant agrees to abide by these and any other terms and conditions, rules and regulations set forth by the ABC and the issuing Commission.
8. Applicant understands and agrees that the ABC reserves the right to amend the terms and conditions for issuing the National MMA ID Card.
9. The National MMA ID Card will expire 5 years from the date it is issued. A new application will need to be completed in order to update or renew your ID.

I certify that I have read and understand the terms and conditions pertaining to the application for a National MMA ID Card, that all information given is my own, is true and correct to the best of my knowledge. I further understand and agree that any false, misstatements or incomplete information on the application will constitute grounds for revoking or denial of the National MMA ID Card, and subject me to a one year suspension at the discretion of the ABC or issuing Commission.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Commission Representative

\_\_\_\_\_  
Date

New Application      Renewal



**ASSOCIATION OF BOXING COMMISSIONS (ABC)**

Application for Boxer's Federal Identification Card

**FEDERAL ID #** \_\_\_\_\_ **EXPIRATION DATE** \_\_\_\_\_

**FULL NAME** \_\_\_\_\_  
First Middle Last

**DATE OF BIRTH** \_\_\_\_/\_\_\_\_/\_\_\_\_ **SOCIAL SECURITY** \_\_\_\_-\_\_\_\_-\_\_\_\_  
Month Day Year

**PLACE OF BIRTH** \_\_\_\_\_  
Country City State

**ADDRESS** \_\_\_\_\_  
Street City Country  
State Zip Code ( ) Phone Number E-mail

**HEIGHT:** \_\_\_\_\_ **WEIGHT:** \_\_\_\_\_ (lbs.) **STANCE (check 1):** RIGHT  LEFT

**HAIR COLOR:** \_\_\_\_\_ **EYE COLOR:** \_\_\_\_\_

**DISTINGUISHING CHARACTERISTICS:** (Tattoos, Scars, etc.) \_\_\_\_\_  
(Chest, Arms, Legs, Neck, Back, etc.)

**MANAGER:** \_\_\_\_\_  
Name E-mail or phone

**PROMOTER:** \_\_\_\_\_  
Name E-mail or phone

**TRAINER:** \_\_\_\_\_  
Name E-mail

**AMATEUR EXPERIENCE:** Yes  No  Record ----- \_\_\_\_\_

**TERMS AND CONDITIONS**

1. Boxers must apply for Boxer Federal ID card in the state in which he/she is a resident.
2. Boxer Federal ID card will not be issued unless an accurate and truthful completed application for ABC Boxer Federal ID Card, **two passport photos and two forms if ID.**
3. Boxer understands that he/she will not be allowed to fight without a Boxer Federal ID Card.
4. Any false or misleading statements on this application may result in the Boxer being placed on the National Suspension list.
5. The ABC reserves the right to amend these terms and conditions.
7. Boxer understands that the ABC with the cooperation with the Boxing Commission that issued the Federal ID Card will settle any disputes or violations of terms and conditions for these cards.
8. Boxer agrees to abide by these terms and conditions and any other rules set forth by the ABC and the Boxing Commission that issued the identification card.

I solemnly swear (or affirm) that the statements made on this application are true and the photograph attached is a true likeness of me. By signing this application I agree to be bound by the rules and regulations of the ABC. If I make a false or misleading statement in this application the ABC at any time thereafter may place me on suspension for one year. I acknowledge that I have read, understand, and agree to the terms and conditions of the ABC Boxer Federal Identification Card.

\_\_\_\_\_  
Applicant's Signature Date

\_\_\_\_\_  
Commission Representative Date