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
- ☐ Shortness of breath
- ☐ Frequent head aches
- ☐ Spitting blood
- ☐ Rupture (hernia)
- ☐ Swollen joints
- ☐ Convulsions (fits)
- ☐ Cerebral hemorrhage or any other serious injury
- ☐ Chest pain
- ☐ Rheumatism
- ☐ Chronic cough
- ☐ Operations
- ☐ Diabetes
- ☐ Bleeding disorder

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: ____

____

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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	
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