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: _____

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 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**

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