

# PHYSICIAN'S LICENSING EXAM BOXING/MMA/KICKBOXING



Legal Name: \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_  
Street City State Country

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  M  F Federal/National ID#: \_\_\_\_\_

**PHYSICAL EXAM:** This section is to be completed by the examining physician.

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Temp: \_\_\_\_\_  Afebrile RR: \_\_\_\_\_ BP: \_\_\_\_\_/\_\_\_\_\_ HR: \_\_\_\_\_

	Normal	Abnormal		Normal	Abnormal	Deferred
<b>General</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Abd.</b> (Hernias)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>HEENT</b> Head	<input type="checkbox"/>	<input type="checkbox"/>	(Masses/Tenderness)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PERRLA/EOMI	<input type="checkbox"/>	<input type="checkbox"/>	<b>Ext.</b> Extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Periorbital Regions	<input type="checkbox"/>	<input type="checkbox"/>	Hands/Wrists	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ears/Hearing (grossly)	<input type="checkbox"/>	<input type="checkbox"/>	Knuckle Push-ups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jaw/Oropharynx/Teeth	<input type="checkbox"/>	<input type="checkbox"/>	Duck/Crab walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nose (stability, obstruction)	<input type="checkbox"/>	<input type="checkbox"/>	<b>Skin</b> (Rashes/Lacerations)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lymph Nodes	<input type="checkbox"/>	<input type="checkbox"/>	<b>Neuro.</b> Alertness/Orientation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck	<input type="checkbox"/>	<input type="checkbox"/>	Cranial Nerves (grossly)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Vision</b> Acuity (grossly)	<input type="checkbox"/>	<input type="checkbox"/>	Tandem Gait	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peripheral/Fields (grossly)	<input type="checkbox"/>	<input type="checkbox"/>	Romberg/Pronator Drift	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Heart</b> Rhythm/Sounds/Murmurs	<input type="checkbox"/>	<input type="checkbox"/>	Finger to Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Chest</b> Lungs	<input type="checkbox"/>	<input type="checkbox"/>	Reflexes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ribs	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Abnormalities:** \_\_\_\_\_

<b>MEDICAL TESTING:</b>	Negative/ Normal	Positive	Not Reviewed	Not Required	Date of test/exam
Hepatitis B Surface Antigen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
Hepatitis C Antibody	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
HIV Antibody or Quantitative RNA (circle)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
CT Scan/MRI Brain (circle)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
EKG	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
Ophthalmologic Examination (Must be performed by MD/DO)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
Neurologist Examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
Women: HCG Urine/Serum (circle)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____

I hereby certify that based on the statements made by the participant on the reverse side of this form, my physical findings, and pending any medical testing not yet reviewed, it is my opinion that said participant is in good physical condition and  
 IS  IS NOT medically cleared to be licensed as a competitor in professional boxing/mixed martial arts/kickboxing.

Reason if not cleared for competition: \_\_\_\_\_

The athlete presented a valid form of photo I.D. and I, the examiner, have personally verified his/her identity.

Physician's Name, M.D./D.O. \_\_\_\_\_ Signature \_\_\_\_\_ License No. \_\_\_\_\_ Date \_\_\_\_\_

Office Address \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Rev. 06/28/16

