



# BC Athletic Commissioner - AMATEUR -



## AMATEUR CONTESTANT Annual Physical Examination Form → To be completed by a Licensed Physician ←

### A. APPLICANT INFORMATION

Name:	Surname	First Name	Date of Birth (yyyy-mm-dd)
-------	---------	------------	----------------------------

### B. DIAGNOSTIC EVALUATION (must be completed by licensed Physician)

I hereby certify that I have examined \_\_\_\_\_ Date of Exam \_\_\_\_\_  
 (print contestant's full legal name) (yyyy-mm-dd)

In addition I have examined the **attached** blood test results (as specified below) and certify that they show no indication that the applicant is infectious for any of the diseases noted below.

- HIV
- Acute Hepatitis B
- Chronic Hepatitis B (test panel should include HBsAg surface antigen test)
- Hepatitis C

Contestants over 35 years of age must also undergo a cardiac stress test and a **copy of the test report attached**

Normal  Abnormal

Weight on Day of Exam: \_\_\_\_\_

#### MUST CHECK ONE:

- This individual is **FIT** to compete in combat sports at this time.
- This individual is **NOT FIT** to compete in combat sports at this time.

Name of Physician: \_\_\_\_\_

Name of Professional Governing Body: \_\_\_\_\_ Registration #: \_\_\_\_\_

Office Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Email: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

**TEST RESULTS MUST BE ATTACHED TO THIS FORM**