

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 (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 Weight on Day of Exam:				
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□ Normal □ Abnormal Weight on Day of Exam:	 indication that the applicant is infectious for an HIV Acute Hepatitis B Chronic Hepatitis B (test panel should inclided) Hepatitis C 	ny of the diseases noted below. ude HBsAg surface antigen test)	
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☐ 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:	☐ This individual is NOT FIT to compete in	•		
Name of Professional Governing	Name of Professional Governing			
Body: Registration #:	•	Regis	tration #:	
Office Address:	·			
Telephone Number: Fax Number:		Fax N	lumber:	
Email:	·			
Physician Signature:				

TEST RESULTS MUST BE ATTACHED TO THIS FORM