BC Athletic Commissioner
- PROFESSIONAL -

PROFESSIONAL CONTESTANT
90 DAY 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