



**BC Athletic Commissioner
- AMATEUR CONTESTANT MEDICAL EXAMINATION -**



A. APPLICANT INFORMATION - must be completed by license applicant

| | | |
|------------------------|----------------------------|------------|
| Applicant Information: | Surname | First Name |
| | Date of Birth (yyyy-mm-dd) | Age |

Combat Sport History

No. of Amateur Matches: _____ Amateur Fight Record: _____ Date of Last Match: _____ Result of Last Match: _____
(W-L-D) (yyyy-mm-dd)

No. of Losses via KO: _____ No. of KO Losses Within 12 Months: _____ Date of last KO Loss: _____
(yyyy-mm-dd)

B. MEDICAL EXAMINATION - must be completed by licensed physician (M.D.)

Height: _____ Weight: _____ Temp: _____ RR: _____ BP: _____ / _____ HR: _____

Health History – Has the applicant experienced any of the following?

| | Yes | No | | Yes | No |
|----------------------------------|--------------------------|--------------------------|-------------------------------------|--------------------------|--------------------------|
| Seizure, headaches, or dizziness | <input type="checkbox"/> | <input type="checkbox"/> | Unusual shortness of breath | <input type="checkbox"/> | <input type="checkbox"/> |
| Head /brain injury/concussion | <input type="checkbox"/> | <input type="checkbox"/> | Lung disease (e.g. asthma) | <input type="checkbox"/> | <input type="checkbox"/> |
| Feeling faint or passing out | <input type="checkbox"/> | <input type="checkbox"/> | Recent fractures or sprains | <input type="checkbox"/> | <input type="checkbox"/> |
| Nasal fracture | <input type="checkbox"/> | <input type="checkbox"/> | Neck or back injury | <input type="checkbox"/> | <input type="checkbox"/> |
| Changes to vision | <input type="checkbox"/> | <input type="checkbox"/> | Abdominal pain, swelling, or hernia | <input type="checkbox"/> | <input type="checkbox"/> |
| Double or blurred vision | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes, thyroid, or liver disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Eye injury/trauma | <input type="checkbox"/> | <input type="checkbox"/> | Blood disorder or bleeding problem | <input type="checkbox"/> | <input type="checkbox"/> |
| Hearing problems | <input type="checkbox"/> | <input type="checkbox"/> | Sickle cell trait or disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest pains, palpitations | <input type="checkbox"/> | <input type="checkbox"/> | Recent illness or fever | <input type="checkbox"/> | <input type="checkbox"/> |
| High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | Skin infections or blisters | <input type="checkbox"/> | <input type="checkbox"/> |
| Irregular heartbeat or murmur | <input type="checkbox"/> | <input type="checkbox"/> | | | |

If "Yes" to any of the above, explain: _____

Your personal information is being collected by the Commissioner or his or her delegate under sections 26(a) and 26(c) of the Freedom of Information and Protection of Privacy Act, for the purpose of registering applications by the Athletic Commissioner for Combat Sports. For questions regarding the collection of personal information please contact the Office of the BC Athletic Commissioner at 250-952-6735 (in Victoria) or 1-888-952-6760 (toll-free).



**BC Athletic Commissioner
- PROFESSIONAL MEDICAL EXAMINATION -**



B. MEDICAL EXAMINATION (continued) - must be completed by licensed physician (M.D.)

Physical Exam

| | | Yes | No | If yes, explain |
|--------------|--|--------------------------|--------------------------|------------------------|
| Neurological | Evidence of disease or disorder of the nervous system? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Head/Neck | Non-healed fracture or sprain to facial bones, nose, or jaw? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| | Enlargement of the thyroid or lymphatic glands? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Hearing | Loss or impairment? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Heart | Abnormal pulse? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| | Abnormal murmur? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| | High blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Respiratory | Abnormal breath sounds? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| | Fracture or injury to ribs? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Hands | Evidence of swelling or injury? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Skin | Any rashes, lesions, or other unhealed lacerations? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| General | Any abnormality that prohibits participation in combat sports? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

Laboratory Tests Required – results must be provided

| | | | |
|------------------------|--|----------|--|
| Hematology: | HBsAG (surface antigen) | Hep C Ab | HIV |
| Cardiovascular: | ECG (aged 36-39) (results reviewed by licensed physician) | | Cardiac Stress test (aged 40 and over) (Accompanied by cardiologist report) |

I hereby certify that I have examined _____ on this date _____
(Name of applicant) (yyyy-mm-dd)

in preparation to compete in professional combat sports such as boxing, kickboxing, and / or MMA, and I find that the applicant:

is fit to compete in combat sports **is not fit to compete** in combat sports

Physician Name (printed) Signature

Governing Body License No Physician or clinic stamp