



**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**

		<b>Yes</b>	<b>No</b>	<b>If yes, explain</b>
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

<b>Hematology:</b>	HBsAG (surface antigen)	Hep C Ab	HIV
<b>Cardiovascular:</b>	ECG (aged 36 and older) (results reviewed by licensed physician)		

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