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: _____ (W-L-D) Date of Last Match: _____ (yyyy-mm-dd) Result of Last Match: _____

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	☐	☐	Unusual shortness of breath	☐	☐
Head /brain injury/concussion	☐	☐	Lung disease (e.g. asthma)	☐	☐
Feeling faint or passing out	☐	☐	Recent fractures or sprains	☐	☐
Nasal fracture	☐	☐	Neck or back injury	☐	☐
Changes to vision	☐	☐	Abdominal pain, swelling, or hernia	☐	☐
Double or blurred vision	☐	☐	Diabetes, thyroid, or liver disease	☐	☐
Eye injury/trauma	☐	☐	Blood disorder or bleeding problem	☐	☐
Hearing problems	☐	☐	Sickle cell trait or disease	☐	☐
Chest pains, palpitations	☐	☐	Recent illness or fever	☐	☐
High blood pressure	☐	☐	Skin infections or blisters	☐	☐
Irregular heartbeat or murmur	☐	☐			

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
- AMATEUR 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?	☐	☐	
Head/Neck	Non-healed fracture or sprain to facial bones, nose, or jaw?	☐	☐	
	Enlargement of the thyroid or lymphatic glands?	☐	☐	
Hearing	Loss or impairment?	☐	☐	
Heart	Abnormal pulse?	☐	☐	
	Abnormal murmur?	☐	☐	
	High blood pressure?	☐	☐	
Respiratory	Abnormal breath sounds?	☐	☐	
	Fracture or injury to ribs?	☐	☐	
Hands	Evidence of swelling or injury?	☐	☐	
Skin	Any rashes, lesions, or other unhealed lacerations?	☐	☐	
General	Any abnormality that prohibits participation in combat sports?	☐	☐	

Laboratory Tests Required – results must be provided

Hematology:	HBsAG (surface antigen)	Hep C Ab	HIV
Cardiovascular:	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