NEVADA STATE ATHLETIC COMMISSION 3300 W SAHARA AVE., SUITE 450 LAS VEGAS, NV 89102

TELEPHONE (702) 486-2575 FACSIMILE (702) 486-2577

PHYSICAL EXAMINATION REPORT FOR AN AMATEUR TO TURN PROFESSIONAL PROFESSIONAL BOXER/UNARMED COMBATANT MALE FEMALE

| | | | | | | // | | | |
|--|---|--|----------------------|----------------------------|--------------------------------|--|--|--|--|
| Name | | Ring Na | Ring Name | | (Telephone) | Date of Birth | | | |
| Address (street) | | (city) | (city) | | (state) | (zip code) | | | |
| PHYSICAL HIST | ORY: Has an | nlicant ever had a | ny of the t | following c | onditions: | | | | |
| PHYSICAL HISTORY: Has applicant ever had any of the following conditions: ☐ Fainting spells ☐ Rupture (hernia) ☐ Chest pains ☐ Operations | | | | | | | | | |
| ☐ Shortness of breath ☐ St | | ☐ Swollen joint | □ Swollen ioints | | ımatism | ☐ Diabetes | | | |
| □ Freq | ☐ Convulsions | nvulsions (fits) | | nic cough | ☐ Bleeding Disorder | | | | |
| ☐ Spitti | ng of blood | ☐ Cerebrai ner | morrnage | or any oth | er serious head ir | njury | | | |
| Number of knockouts received Longest duration of unconsciousness | | | | Date of la | ast knockout | | | | |
| | efore resuming box | | ckout | | | | | | |
| If yes, e | conscious in other xplain | | | | | | | | |
| Amateur boxing record Wins _ | | Losse | Losses | | Oraws | | | | |
| Amateur MMA record Wins | | Losses | | Draws | | | | | |
| PHYSICAL EXA | - | | | l latalat | \\/-:- -4 | Tanasanatuna | | | |
| | | | | | | Temperature | | | |
| | | | | | | Neck | | | |
| Pulse at rest Blood pressure at rest | | | | | | | | | |
| Pulse after 100 h | nops | | | · - | · · | | | | |
| | | | | = | e 2 minutes later _ | | | | |
| | : □ Yes □ No | | ☐ Yes | | | | | | |
| Heart: | Pulse rhythm | - | ☐ Irreg | | Apical impulse | - | | | |
| | Enlargement | □ Yes | □ No | | Murmurs□ Yes | □ No | | | |
| Lungs: | Rales | ☐ Yes | □ No | | | | | | |
| Breasts: Mass | ☐ Yes | □ No | | Tendern | ess □ Yes | □ No | | | |
| | Discharge | ☐ Yes | □ No | | | | | | |
| Abdomen: | Enlargement of I | | | | Enlargement of S | | | | |
| | Hernia | | □ No | | □ Inguinal | | | | |
| Testicles: Reflexes: | Normal Punile | ☐ Yes | ⊔ No | Remarks | : | Babinski | | | |
| Skin: | | | | | | d wounds: | | | |
| SKIII. | Rasii | Boils | | A | ny otner unnealed | a wounds | | | |
| Electrocardio Urinalysis SEROLOGY: All tests must be a. HIV | within normal limit | cings) port with applican ts to meet the Nev | t's name a | and date th sing requil | ne tests were perf rements. | ONAL: ormed must be submitted. In certain situations a Hepatitis | | | |
| B Core A c. Hepa d. CBC | Antibody test will be a atitis C Antibody | acceptable as confirm - If positive confirm | mation. nation by | • | · | m oertain situations a Hepatitis | | | |
| e. Elect | | | | | | | | | |

PHYSICAL EXAMINATION AMATEUR TO PROFESSIONAL REPORT - PAGE TWO

| EYE HIS | STORY: | Has applicant ev | ver had any of the fo | llowing conditions: | | | | | |
|---|---|---|--|---|---|---|--|--|--|
| (1) | Blurred vision ? ☐ Yes ☐ No | | | | | | | | |
| (2) | Surgical procedures done to his/her eye(s) or the tissues around the eye other than simple sutures of the skir around the eye? \Box Yes \Box No | | | | | | | | |
| (3) | Has applicant ever been informed by a physician that he/she had significant eye problems such as retina detachment, retinal tear, primary or secondary glaucoma, aphakia, pseudophakia, or dislocated lens? ☐ Yes ☐ No | | | | | | | | |
| YOU | MUST ALSO G | O TO AN OP | HTHALMOLOG | IST FOR A DIL | ATED EYE EX | <u>AMINATION</u> | | | |
| EXAMINING PHYSICIAN: - The following section must be completed. | | | | | | | | | |
| any si | e evaluated the ignificant abnor o clarify any pro | malities eith | | | • | | | | |
| PLEAS | SE CHECK ONE: | . I HAVE □ | HAVE NOT | MEDICA | LLY CLEARED | TO FIGHT | | | |
| LICENSEI | D PHYSICIAN'S NAME AI | ND LICENSE NUMB | ER (PLEASE PRINT) | PHYSIC | CIAN'S SIGNATURE | | | | |
| STREET | ADDRESS | | | DATE | | | | | |
| OTKLET / | ADDICEOS | | | , | | | | | |
| CITY | | STATE | ZIP CODE | PHONE | NUMBER | | | | |
| APPLI | CANT: | | | | · · · · · · · · · · · · · · · · · · · | | | | |
| | e under penalty of pe I realize that any inte | | | | | | | | |
| "Commi persona containe person v making | y AUTHORIZE the A ission"), pursuant to all information with red in any of the Corwhom the Commissimy medical history a dical condition, care | the provisions of respect to my st mmission's reco ion determines h available including | f NRS/NAC Chapter tatus and licensure ords. I further authonas a need to know. | 467, to RELEASE and as a professional contribution in the Commission I agree that I will full | ny and all medical i unarmed combata n to release this ir ly cooperate with th | nformation and/or nt which may be nformation to any ne Commission in | | | |
| attempts | RELEASE, PROMIS is to obtain any of th JANT NOT TO SUE a ssion on the basis of | ne foregoing info any persons, firm | ormation, and I furth ns, institutions or age | er RELEASE, PRO ncies providing such | MISE TO HOLD In information to represent | HARMLESS, and resentatives of the | | | |
| I further | r agree that a photog | graphic copy of t | his Authorization sh | all be valid as the o | riginal. | | | | |
| DATE | | | | SIGNATURE OF | APPLICANT | | | | |
| LOCAT | TION | | | NAME PRINTED | | | | | |

Revised 01/2010 Saves as: PHYSICAL-AMA