PHYSICAL EXAMINATION REPORT
PROFESSIONAL BOXER/UNARMED COMBATANT
☐ MALE  ☐ FEMALE

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<tr>
<th>Name</th>
<th>Ring Name</th>
<th>(Telephone)</th>
<th>Date of Birth</th>
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**Address (street)**  |  **(city)**  |  **(state)**  |  **(zip code)**  |
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**PHYSICAL HISTORY:** Has applicant ever had any of the following conditions:

- Fainting spells
- Rupture (hernia)
- Chest pains
- Operations
- Shortness of breath
- Swollen joints
- Rheumatism
- Diabetes
- Frequent headaches
- Convulsions (fits)
- Chronic cough
- Bleeding Disorder
- Spitting of blood
- Cerebral hemorrhage or any other serious head injury

Number of knockouts received  ___________________________ Date of last knockout __________________________________

Longest duration of unconsciousness

Ever knocked unconscious in other sport or in any other way? Yes ☐ No ☐

If yes, explain    ____________________________________________________________________________________

Amateur boxing record

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<tr>
<th>Wins</th>
<th>Losses</th>
<th>Draws</th>
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Professional boxing record

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Amateur MMA record

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Professional MMA record

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**PHYSICAL EXAMINATION:**

General appearance ___________________________ Height ________ Weight ________ Temperature _______________

Disabling scars ___________________________ Mouth ________ Teeth ________ Tonsils ________ Neck ________

Pulse at rest ___________________________ Blood pressure at rest ___________________________

Pulse after 100 hops __________________    Blood pressure after 100 hops ______________________

Blood pressure 2 minutes later __________________

Enlarged glands:  ☐ Yes  ☐ No  Goiter:  ☐ Yes  ☐ No

Heart:  Pulse rhythm  ☐ Regular  ☐ Irregular  Apical impulse  ☐ Heavy  ☐ Normal

Enlargement  ☐ Yes  ☐ No  Murmurs  ☐ Yes  ☐ No

Lungs:  Rales  ☐ Yes  ☐ No

Breasts: Mass  ☐ Yes  ☐ No  Tenderness  ☐ Yes  ☐ No

Discharge  ☐ Yes  ☐ No

Abdomen:  Enlargement of liver  ☐ Yes  ☐ No  Enlargement of Spleen  ☐ Yes  ☐ No

Hernia  ☐ Yes  ☐ No  Femoral  ☐  Inguinal  ☐  Ventral  ☐

Testicles:  Normal  ☐ Yes  ☐ No  Remarks:

Reflexes:  Pupils ________ Knee jerks ________ Romberg ________ Babinski ________

Skin:  Rash ________ Boils ________ Any other unhealed wounds:

REMARKS: ____________________________________________________________________________________________

__________________________________________________________________________________________

SEROLOGY: The original lab report with applicant’s name and date the tests were performed must be submitted.
All tests must be negative to meet the Nevada licensing requirements.

1. HIV
2. Hepatitis B Surface Antigen - If positive confirmation by Neutralization technique.
In certain situations a Hepatitis B Core Antibody test will be acceptable as confirmation.
3. Hepatitis C Antibody - If positive confirmation by RIBA (HCV Confirmation).
EYE HISTORY:

Has applicant ever had any of the following 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 skin around the eye?  □ Yes  □ No

(3) Has applicant ever been informed by a physician that he/she had significant eye problems such as retinal detachment, retinal tear, primary or secondary glaucoma, aphakia, pseudophakia, or dislocated lens?  □ Yes  □ No

YOU MUST ALSO GO TO AN OPHTHALMOLOGIST FOR A DILATED EYE EXAM FOR LICENSURE

EXAMINING PHYSICIAN: - The following section must be completed.

I have evaluated the above named athlete and ordered the requested exams. Listed are any significant abnormalities either in my physical or the testing. Also listed are the steps I took to clarify any problem.

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

PLEASE CHECK ONE: I HAVE □ HAVE NOT □ MEDICALLY CLEARED TO FIGHT

LICENSED PHYSICIAN'S NAME AND LICENSE NUMBER (PLEASE PRINT)  PHYSICIAN'S SIGNATURE

STREET ADDRESS

DATE

CITY  STATE  ZIP CODE  PHONE NUMBER

APPLICANT:

I declare under penalty of perjury under the laws of the State of Nevada, that the foregoing information is true & correct; further I realize that any intentional misrepresentation may result in disciplinary action against my license.

I hereby AUTHORIZE the Athletic Commission of the Department of Business and Industry of the State of Nevada (the "Commission"), pursuant to the provisions of NRS/NAC Chapter 467, to RELEASE any and all medical information and/or personal information with respect to my status and licensure as a professional unarmed combatant which may be contained in any of the Commission's records. I further authorize the Commission to release this information to any person whom the Commission determines has a need to know. I agree that I will fully cooperate with the Commission in making my medical history available including, but not limited to, giving oral or written reports to the Commission regarding my medical condition, care and/or treatment.

I further RELEASE, PROMISE TO HOLD HARMLESS, and COVENANT NOT TO SUE the Commission on the basis of its attempts to obtain any of the foregoing information, and I further RELEASE, PROMISE TO HOLD HARMLESS, and COVENANT NOT TO SUE any persons, firms, institutions or agencies providing such information to representatives of the Commission on the basis of its disclosures. I have signed this Release voluntarily and of my own free will.

I further agree that a photographic copy of this Authorization shall be valid as the original.

DATE  SIGNATURE OF APPLICANT

LOCATION  NAME PRINTED

Revised 01/2010  Saved as PHYSICALEXAM