

NEVADA STATE ATHLETIC COMMISSION
3300 W. SAHARA AVENUE, SUITE 450
LAS VEGAS, NV 89102-3200
TELEPHONE (702) 486-2575 *** FACSIMILE (702) 486-2577

REFEREE PHYSICAL EXAMINATION REPORT

Name _____ (Telephone) _____ Date of Birth _____
Address (street) _____ (city) _____ (state) _____ (zip code) _____

PHYSICAL HISTORY: Has applicant ever had any of the following conditions:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Rupture (hernia) | <input type="checkbox"/> Chest pains | <input type="checkbox"/> Operations |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Swollen joints | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Convulsions (fits) | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> Spitting of blood | <input type="checkbox"/> Cerebral hemorrhage or any other serious head injury | | |

If yes, explain _____

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 _____
Pulse 2 minutes later _____ 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 Ears _____ Nose _____
Abdomen: Enlargement of liver Yes No Enlargement of Spleen Yes No
Genitalia: Discharge _____ Yes _____ No _____ Varicocele _____ 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: _____

YOU MUST GO TO AN OPHTHALMOLOGIST OR AN OPTOMETRIST FOR AN EYE EXAMINATION

EXAMINING PHYSICIAN: THE FOLLOWING SECTION MUST BE COMPLETED.

I have examined the above named subject and find him in:

_____satisfactory _____unsatisfactory
condition to be licensed as a professional REFEREE.

LICENSED PHYSICIAN'S NAME AND LICENSE NUMBER (please print) PHYSICIAN'S SIGNATURE Telephone Number

STREET ADDRESS City State Zip DATE

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

SIGNATURE OF APPLICANT DATE