NEVADA STATE ATHLETIC COMMISSION
555 E. WASHINGTON AVENUE, SUITE 1500
LAS VEGAS, NV 89101
TELEPHONE (702) 486-2575 FACSIMILE (702) 486-2577

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

_____ / _____ / _____
Name Ringname (Telephone) Date of Birth

_____
Address (street) (city) (state) (zip code)

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 _____
Length of time before resuming boxing after last knockout _____
Ever knocked unconscious in other sport or in any other way ? Yes ☐ No ☐
If yes, explain _____
Amateur boxing record Wins _____ Losses _____ Draws _____
Professional boxing record Wins _____ Losses _____ Draws _____

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: _____
Pelvic: 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 qualitative PCR (polymerase chain reaction)

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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

EYE EXAMINATION:

	Right / Left		Right / Left		Right / Left
Vision without glasses	_____/_____	Vision with glasses	_____/_____	Visual fields	_____/_____

YOU MUST ALSO GO TO AN OPHTHALMOLOGIST FOR A DILATED EYE EXAMINATION

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