

OREGON STATE ATHLETIC COMMISSION  
 3400 State St. Ste. G-750  
 Salem OR, 97301  
 TELEPHONE: 503-378-8739 FAX: 503-378-6878

**REPORT OF PHYSICAL EXAMINATION**

**PROFESSIONAL BOXER/MIXED MARTIAL ARTS FIGHTER/REFEREE**

|                |                   |
|----------------|-------------------|
| Name:          | Ring Name:        |
| Home Address:  | City: State: Zip: |
| Date of Birth: | Age:              |

**HISTORY:**

Has the applicant ever had any of the following?

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Swollen Joints     | <input type="checkbox"/> Rheumatism        | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Chronic Cough      | <input type="checkbox"/> Spitting of Blood | <input type="checkbox"/> Blurring of Vision  |
| <input type="checkbox"/> Convulsions (Fits) | <input type="checkbox"/> Fainting Spells   | <input type="checkbox"/> Operations          |
| <input type="checkbox"/> Rupture (Hernia)   | <input type="checkbox"/> Wear/Worn Glasses | <input type="checkbox"/> Diabetes            |
| <input type="checkbox"/> Dizzy Spells       | <input type="checkbox"/> Bleeding Disorder |  |

|  |
|--|
| How many knockouts has fighter suffered: _____ Date of last knockout: _____ Length of time before fighting after last knockout: _____ Longest duration of unconsciousness: _____ |
| Ever knocked unconscious in other sports or in any other way: <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes, explain fully:                                 |



**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 |         |  |

| EYES                    |        |       |   |
|-------------------------|--------|-------|---|
| Vision without glasses: | Right: | Left: | Pupils equal: <input type="checkbox"/> Yes <input type="checkbox"/> No Goiter: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Comments:               |        |       |   |

| EARS      |       |
|-----------|-------|
| Ears:     | Nose: |
| Comments: |       |

| HEART         |          |            |               |                 |
|---------------|----------|------------|---------------|-----------------|
| Pulse Rhythm: | Regular: | Irregular: | Apical Pulse: | Heaving: Normal |
| Comments:     |          |            |               |                 |

| LUNGS     |  |
|-----------|--|
| Rales:    | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Comments: |  |

| ABDOMEN  |   |
|--|---|
| Enlargement of liver: <input type="checkbox"/> Yes <input type="checkbox"/> No | Enlargement of spleen: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Comments:  |   |

| GENITALIA   |  |
|---|--|
| Discharge: <input type="checkbox"/> Yes <input type="checkbox"/> No | Varicocele: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Comments:   |  |

| HANDS  |                  |
|--|------------------|
| Evidence or recent injury, fracture, swelling: | Unhealed Wounds: |

| REFLEXES   |  |
|--|--|
| Pupils: Light & Acuteness: R ____ L ____ Knee Jerks: R ____ L ____ Romberg: R ____ L ____ Babinski: R ____ L ____ Ankle Jerks: R ____ L ____ |  |
| Comments:  |  |

| OTHER                  |             |                  |
|------------------------|-------------|------------------|
| Skin: Rash _____       | Boils _____ | Any other: _____ |
| Urinalysis: (Dipstick) |             |                  |
| Comments:              |             |                  |

**Serology (required):**

- HIV/AIDS – Lab report of a negative result must be submitted.
- Hepatitis B Surface Antigen – Lab report of a negative result must be submitted.
- Hepatitis C Antibody – Lab report of a negative result must be submitted.

**Drug Screen (not required unless requested by Commission):**

Abusive Drugs – The original or certified lab report must be submitted. Prohibited substances include, but are not limited to:

- |  |   |  |
|--|---|--|
| <ul style="list-style-type: none"> <li>• Methadone</li> <li>• Morphine</li> <li>• Meperidine</li> <li>• Propoxyphene</li> <li>• Quinine</li> <li>• Barbiturates</li> </ul> | <ul style="list-style-type: none"> <li>• Glutethimide</li> <li>• Clorpromazine</li> <li>• Codeine</li> <li>• Cocaine</li> <li>• D-Amphetamine</li> <li>• Marijuana</li> </ul> | <ul style="list-style-type: none"> <li>• Any central nervous system stimulant or depressant whether obtained by prescription or otherwise</li> <li>• Heroin</li> <li>• Metabolic steroids</li> </ul> |
|--|---|--|

**The current HIV, Hepatitis and Drug Abuse policy is as follows:**

Every fighter applying for a license in Oregon must present laboratory test results reflecting that the applicant is negative for the presence of the HIV virus and Hepatitis B and C.

Examining Physician’s Comments:

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I (examining physician) have examined the above named subject and find him/her, in my opinion, to be in ( \_\_\_\_ **Satisfactory** \_\_\_\_ **Unsatisfactory** ) condition to be licensed as a Boxer/MMA Fighter/Referee.

\_\_\_\_\_  
Physician’s Name

\_\_\_\_\_  
Physician’s Signature

\_\_\_\_\_  
Address

\_\_\_\_\_  
Date

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Phone Number

I hereby declare under penalty of perjury, that the forgoing history is true and correct; further, I realize that any misrepresentation in said medical history may result in disciplinary action.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date Signed

**FOR OFFICE USE ONLY:**

REVIEWED BY: \_\_\_\_\_ DATE: \_\_\_\_\_