Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935
Madison, WI 53708-8935
Phone #: (608) 261-8503

Office Location: 4822 Madison Yards Way
Madison, WI 53705
E-Mail: dspscombativesports@wisconsin.gov
Website: http://dsps.wi.gov

UNARMED COMBAT SPORTS
INFORMATION FOR CONTESTANT LICENSE APPLICATION

APPLICATION DEADLINE: FOUR (4) business days before the scheduled event (Wis. Admin. Code § SPS 192.15(1)(d)).

Eligibility to obtain the credential:

A person who applies for a contestant's license must be at least 18 years of age and shall provide all of the following:

- An Association of Boxing Commission's federal identification number or national identification number is required before participating in a scheduled contest. If you do not have an identification number, an application form is available on the DSPS website; https://dsps.wi.gov/Pages/Professions/UnarmedCombatSports/Default.aspx.
- Results of a physical examination by a physician and laboratory results conducted no more than 180 days before the date of the application in accordance with Wis. Stat. ch. 448. Copies of laboratory results must accompany this application.

Your application will not be processed or will be delayed unless you:

- ☐ 1) Complete the application information section on the first page. You must complete all sections including your social security number.
- ☐ 2) Complete the certification of legal status section on this application.
- ☐ 3) Complete the contestant's prior bout history on this application.
- ☐ 4) Read and sign the affidavit of applicant and consent for release of medical information.
- ☐ 5) $40 credential fee – Attach check or fill in the credit/debit card section.
- ☐ 6) Complete and attach the medical examination report at the end of this application,
- ☐ 7) Include copies of laboratory blood work results.

Note: The Department may request additional information necessary to determine an applicant's eligibility for a license, such as additional medical reports, training, personal interviews, and observation of training.

Send application and payment to:
Wisconsin Department of Safety and Professional Services
Attention: Unarmed Combat Sports Program
P.O. Box 8935
Madison, WI 53708-8935

Overnight mail delivery and Office location:
Wisconsin Department of Safety and Professional Services
Attention: Unarmed Combat Sports Program
4822 Madison Yards Way
Madison, WI 53705

All other correspondence:
Phone: (608) 261-8503 (*TTY: Contact through Relay)*
Website: http://dsps.wi.gov
E-mail: dspscombativesports@wisconsin.gov

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UNARMED COMBAT SPORTS
CONTESTANT LICENSE APPLICATION

The Department must deny your application if you are liable for delinquent state taxes, UI contributions, or child support (Wis. Stat. §§ 440.12 and 440.13).

APPLICATION DEADLINE: FOUR (4) business days before the scheduled event (Wis. Admin. Code § SPS 192.15(1)(d)).

PLEASE TYPE OR PRINT IN INK ☐ Your name, address, phone number, and e-mail address are available to the public. Check box to withhold street address or PO Box, phone number, and e-mail address from lists of 10 or more credential holders (Wis. Stat. § 440.14).

SECTION 1 - APPLICANT INFORMATION - Check credential type you are applying for (check one)**:**

☐ **Amateur Mixed Martial Arts** (276) ☐ **Amateur Kickboxing** (283) ☐ **Amateur Muay Thai** (285) ☐ **Professional Boxing** (263)
☐ **Professional Mixed Martial Arts** (277) ☐ **Professional Kickboxing** (284) ☐ **Professional Muay Thai** (286)

First Name	**Middle Name**	**Last Name**

Former/Maiden Name (if applicable)		**Check One**	☐ **Male** ☐ **Female**

Date of Birth (month/day/year)	**Phone Number**	**Upcoming Fight Date** (if known) (month/day/year)	
☐☐/☐☐/☐☐☐☐	☐☐☐-☐☐☐-☐☐☐☐ _____	☐☐/☐☐/☐☐☐☐	**APPLICATION DEADLINE IS 4 DAYS BEFORE EVENT**

Street Address or P.O. Box	**City**	**State**	**Zip Code**

Country (if other than United States)	**Gym/Coach**

Social Security Number

☐☐☐-☐☐-☐☐☐☐

Your Social Security Number must be submitted with your application on this form. If you do not have a Social Security Number, you must complete Form #1051. The Department may not disclose the Social Security Number collected except as authorized by law.

E-mail Address (REQUIRED)

SECTION 2 – CONTESTANT'S PRIOR BOUT HISTORY

1. What is the contestant's record? Specify your records in any combative sport you have competed in.

AMATEUR RECORD	_____ WINS	_____ LOSSES	_____ DRAWS
PROFESSIONAL RECORD	_____ WINS	_____ LOSSES	_____ DRAWS

2. What is the date of the contestant's last bout? MONTH _____ DAY _____ YEAR _____

3. If the contestant has never professionally fought, or has not fought, within the last five (5) years, please provide information relating to unarmed combat sports training. Please attach additional pages as needed to prove your training experience.

SECTION 3 – FEE(S)

- **The Wisconsin DSPS license fee is $40.00.** The license is valid for one year from the date it is issued.
- A current Association of Boxing Commissions' mixed martial arts national identification number or a boxing federal identification number is required.
  - If you do not have a National/Federal ID Card, include an additional $10 processing fee **and** ABC Boxer **OR** MMA form.
  - If your National/Federal ID Card is expired, include an additional $10 replacement fee.

Application Fee(s):

☐ **$40.00 (license fee only)**

☐ **$50.00 (license fee and ID fee – attach** ABC Boxer **OR** MMA form.**)**

For Receipting Use Only
276, 277, 263, 283, 284, 285, 286)

SECTION 4 – AFFIDAVIT OF APPLICANT AND CONSENT FOR RELEASE OF MEDICAL INFORMATION

CERTIFICATION OF LEGAL STATUS

I declare under penalty of law that I am (check one):

☐ A citizen or national of the United States, or

☐ A qualified alien or nonimmigrant lawfully present in the United States who is eligible to receive this professional license or credential as defined in the Personal Responsibility and Work Opportunities Reconciliation Act of 1996, as codified in 8 U.S.C. §1601 et. seq. (PRWORA). For questions concerning PRWORA status, please contact the U.S. Citizenship and Immigration Services in the Department of Homeland Security at 1-800-375-5283 or online at http://www.uscis.gov.

Should my legal status change during the application process or after a credential is granted, I understand that I must report this change to the Wisconsin Department of Safety and Professional Services immediately.

CONTINUING DUTY OF DISCLOSURE

I understand that I have a continuing duty of disclosure during the application process. If information I have provided in this application becomes invalid, incorrect, or outdated, I understand that I am obliged to provide any necessary information to ensure the information on my application remains current, valid, and truthful. I understand that credentialing authorities may view acts of omission as dishonesty and that my duty of disclosure during the application process exists until licensure is granted or denied.

AFFIDAVIT OF APPLICANT

I declare that I am the person referred to on this application and that all answers set forth are each and all strictly true in every respect. I understand that failure to provide requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential or for renewal or reinstatement of a credential may result in credential application processing delays; denial, revocation, suspension, or limitation of my credential; or any combination thereof; or such other penalties as may be provided by law. I further understand that if I am issued a credential, or renewal, or reinstatement thereof, failure to comply with the statutes and/or administrative code provisions of the licensing authority will be cause of disciplinary action.

By signing below, I am signifying that I have read the above statements (Certification of Legal Status, Continuing Duty of Disclosure and Affidavit of Applicant) and understand the obligation I have as an applicant or credential-holder should information I have provided to the Department of Safety and Professional Services change.

Applicant's Signature (If unable to provide a digital signature print and sign form.)	**Date** (mm/dd/yyyy)
	__/__/____

I, Print Name _____, hereby authorize any physician, staff, or any other medical professional who provided the results of my physical, lab work, or any medical documentation from other commissions to provide the Wisconsin Unarmed Combat Commission, or any member thereof, and the Wisconsin Department of Safety and Professional Services, or any attorney, investigator, employee, or agent thereof, 4822 Madison Yards Way, Madison, Wisconsin, with copies of all documents regarding my medical and treatment records. This includes but is not limited to: intake summary; physicians' progress notes; laboratory tests; x-rays; consultation reports; nursing notes; medications prescribed; discharge summary; diagnosis and prognosis records; and collection, submission, and analysis reports of body fluid screens. This is to include records relating to HIV testing and treatment if such treatment has been given.

This disclosure is being made for the purposes of receiving a license to fight as an unarmed combat contestant and any legal investigation needed to verify information submitted to support such application for license or subsequent medical treatment. Unless revoked earlier, this consent regarding records is effective for one (1) year from the date of my signature. I understand that I may revoke this consent at any time and that information obtained prior to revocation as a result of this consent may be used after the above expiration date or revocation. A reproduced copy of this consent form shall be as valid as the original.

I further authorize discussion with the above-listed persons regarding any matters relating to my treatment.

Applicant's Signature (If unable to provide a digital signature print and sign form.)	**Date** (mm/dd/yyyy)
	__/__/____

Wisconsin Department of Safety and Professional Services

SECTION 5 – LICENSE FEE(S) (nonrefundable) – Valid for one year from issue date:

Fee selection must match the selection you chose on the bottom of Page 1.

☐ **$40.00 (license fee only)**

☐ **$50.00 (license fee and National/Federal ID Card fee – attach** ABC Boxer **OR** MMA form.**)**

- **Pay by Check or Money Order -** Make checks payable to State of WI – DSPS/ P.O. Box 8935 Madison, WI 53708-8935

OR

- **Pay by Credit or Debit Card** – Fill in the information below.

Please Note: For all credit and debit card transactions, a 2% convenience fee will be assessed and will appear as a separate charge on your statement. This fee is non-refundable

Cardholder's Name:		**Daytime Phone Number:**	
		☐☐☐ - ☐☐☐ - ☐☐☐☐ _____	
Cardholder's Address: (Number/Street)	(City)	(State)	(Zip Code)
Credit Card Number:		**Expiration Date:** (month / year)	
☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐		☐☐ / ☐☐☐☐	
Card Type (select one):	☐ VISA ☐ MASTER CARD ☐ DISCOVERY ☐ AMERICAN EXPRESS		
Security Code:	☐☐☐☐		

I understand by signing below, I authorize the State of Wisconsin Department of Safety and Professional Services to charge my credit card for the above amount and a 2% convenience fee assessed at the time of processing.

Cardholder's Signature (Print and Sign Form):

SECTION 6 – CONTESTANT MEDICAL EXAMINATION REPORT

Name		Date of Birth (mo/day/year)	/ /

Please answer the following questions. Attached additional sheets if necessary.

1.	**Are you 40 years of age or older**? **If yes, submit the following examination results *in addition* to the other medical examinations listed below:** **(a) MRI or MRA brain examination;** **(b) metabolic blood profile;** **(c) stress echocardiogram examination with the cardiology clearance; and** **(d) chest x-ray taken within 2 years.**	☐ Yes ☐ No
2.	Have you had any illness or injuries within the last 5 years? **If yes, describe:**	☐ Yes ☐ No
3.	Have you ever had severe headaches, fainting spells, or dizziness? **If yes, describe:**	☐ Yes ☐ No
4.	Do you have any medical condition that may affect your ability to compete? **If yes, describe:**	☐ Yes ☐ No
5.	List your record. **Amateur:** Wins_____ Losses_____ Draws_____ **Professional:** Wins_____Losses_____Draws_____	
6.	What is the date of your last bout? Month____ Day ____ Year _____	
7.	Have you ever been injured in a bout? **If yes, describe the injury or injuries:**	☐ Yes ☐ No
8.	Have you ever been knocked out? **If yes, answer the following questions: 8a) Date of last knock out?** **Month_____ Day_____ Year_____ 8b) How long were you unconscious? _____**	☐ Yes ☐ No

IMPORTANT NOTE: Your physician must complete the remainder of this form in its entirety. This completed form and proof of blood test results must be submitted with the application.

VITALS	**Height**	**Weight**	**Temperature**
Pulse		**Blood Pressure**	
Comments			
TENDON REFLEXES	**Knee Jerk** ☐ Normal ☐ Abnormal	**Babinski** ☐ Normal ☐ Abnormal	
Finger-to-Nose ☐ Normal ☐ Abnormal		**Romberg** ☐ Normal ☐ Abnormal	
Comments			
EXTREMITIES/JOINTS	**Hands** ☐ Normal ☐ Abnormal	**Elbows** ☐ Normal ☐ Abnormal	**Feet** ☐ Normal ☐ Abnormal
Ankles ☐ Normal ☐ Abnormal	**Wrists** ☐ Normal ☐ Abnormal	**Shoulders** ☐ Normal ☐ Abnormal	**Knees** ☐ Normal ☐ Abnormal
Hips ☐ Normal ☐ Abnormal	**Comments**		
MISC	**Mouth/Pharynx** ☐ Normal ☐ Abnormal	**Adenopathy** ☐ Normal ☐ Abnormal	
Heart ☐ Normal ☐ Abnormal	**Abdominal Palpation** ☐ Normal ☐ Abnormal	**Boil, Herpes, Impetigo** ☐ Yes ☐ No	
Lungs ☐ Normal ☐ Abnormal	**Hernias** ☐ Normal ☐ Abnormal	**Testis** ☐ Normal ☐ Abnormal ☐ N/A (female)	
Comments			

EYES (*REQUIRED)	Left	Right	Comments
***Distant Vision**	**20/**	**20/**	
***Light Reflex**	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal	
***Accommodation Reflex**	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal	
***Cataracts**	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal	
***Fundi**	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal	

Blood Work Lab Results	**BLOOD WORK LAB RESULTS REQUIRED FOR LICENSING.**

Per Wis. Admin. Code § 192.06(2)(d) the results of the **physical** and the following **negative laboratory test results and interpretation**, conducted **no more than 180 days** before the application date, are required: **(1)** HIV; **(2)** hepatitis B surface antigen; **and (3)** hepatitis C antibody.

PHYSICIAN - PLEASE CHECK ONE	**PHYSICIAN STAMP**
☐ **I have** ☐ **I have not** **Medically cleared this contestant to engage in combat sports.**	

Examiner Name (Printed): **Title** (MD, DO, PA) **Lic#**

Address (Street, City, State, Zip Code) **Phone** - -

Date of Exam (mm/dd/yyyy) / /

Examiner Signature (If unable to provide a digital signature print and sign form.)