Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935
Madison, WI 53708-8935
FAX #: (608) 223-6532
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 UNARMED COMBAT SPORTS CONTESTANT LICENSE APPLICATION

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 bloodwork results.
- ☐ 8) Submit COVID-19 Precaution Form (Form 148C).

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)*
Fax: (608) 223-6532
Website: http://dsps.wi.gov
E-mail: dspscombativesports@wisconsin.gov

Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935
Madison, WI 53708-8935
FAX #: (608) 223-6532
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

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).

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

SECTION 1 - APPLICANT INFORMATION

☐ **MALE** ☐ **FEMALE**

Check credential type you are applying for (check one)**:**

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

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

Phone Number	**Extension** (if applicable)	**Date of Birth** (month/day/year)
- -		/ /

Gym/Coach	**Upcoming Fight Date** (if applicable) (month/day/year)
	/ /

Street Address or P.O. Box

City	**State**	**Zip Code**	**Country** (if other than United States)

Social Security Number	Your Social Security Number or Employer Identification 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.
- -	

Have you ever been licensed in Wisconsin? ☐ Yes ☐ No If yes, list your credential number(s):

E-mail Address

APPLICATION FEE

Application Fee: $40.00 - See page 3 for payment information.

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

Wisconsin Department of Safety and Professional Services

SECTION 2 – 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.

SECTION 3 – 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 4 – AFFIDAVIT OF APPLICANT AND CONSENT FOR RELEASE OF MEDICAL INFORMATION

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 _____ **Date** ☐☐/☐☐/☐☐☐☐

(Print and Sign Form) (Month) (Day) (Year)

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 _____ **Date** ☐☐/☐☐/☐☐☐☐

(Print and Sign Form) (Month) (Day) (Year)

Wisconsin Department of Safety and Professional Services

SECTION 5 – CREDENTIAL FEE (nonrefundable): $40.00 (Credential is valid for one year from date issued.)

- **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 Address:

Street | City | State | Zip Code

Credit Card Number:

☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐

Expiration Date:

☐☐ / ☐☐☐☐

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/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	**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	

Bloodwork Interpretation*	**Date Drawn**	**Date of Results**	**Results**	**Comments**
HIV			☐ Normal ☐ Abnormal	
Hepatitis B Surface Antigen			☐ Normal ☐ Abnormal	
Hepatitis C antibody			☐ Normal ☐ Abnormal	
***BLOODWORK LAB RESULTS MUST BE SENT WITH PHYSICAL**				

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** (Print and Sign Form)