6. Contestant Medical Examination Report:

Name:	**Birth date:**

Please answer the following questions:

1. Are you 40 years of age or older? ☐ **Yes** ☐ **No**
   If yes, you are required to submit the results of the following examinations in addition to all the other required medical examinations listed below:
   - MRI/MRA brain examination
   - Metabolic blood profile
   - A stress echocardiogram examination with the cardiology clearance
   - A chest x-ray that has been given within 2 years

2. Have you had any illness or injuries within the last 5 years? ☐ **Yes** ☐ **No** If yes, describe: _____
3. Have you ever had severe headaches, fainting spells, or dizziness? ☐ **Yes** ☐ **No** If yes, describe: _____
4. Do you have any medical condition that may affect your ability to compete? ☐ **Yes** ☐ **No** If yes, describe: _____
5. List your record: **Amateur** _____ **Professional** _____
6. What is the date of your last bout? _____
7. Have you ever been injured in a bout? ☐ **Yes** ☐ **No** If yes, describe injury: _____
8. Have you ever been knocked out? ☐ **Yes** ☐ **No** If yes, date of last knock out _____ How long were you unconscious? _____

Your physician must complete the remainder of this form in its entirety, including the results from your blood tests. This completed form and any additional examination results must be submitted with the application.

Vitals		
Height:	Pulse:	Blood Pressure:
Weight:	Temperature:	
Comments:		

Tendon Reflexes	
Knee Jerk: Normal or Abnormal	Rhomberg: Normal or Abnormal
Babinski: Normal or Abnormal	Finger to Nose: Normal or Abnormal
Comments:	

Extremities / Joints			
Hands: Normal or Abnormal	Elbows: Normal or Abnormal	Feet: Normal or Abnormal	Ankles: Normal or Abnormal
Wrists: Normal or Abnormal	Shoulders: Normal or Abnormal	Knees: Normal or Abnormal	Hips: Normal or Abnormal
Comments:			

Misc		
Mouth and Pharynx: Normal or Abnormal	Adenopathy: Normal or Abnormal	Heart: Normal or Abnormal
Abdominal Palpation: Normal or Abnormal	Testis: Normal or Abnormal	Lungs: Normal or Abnormal
Boils, Herpes, Impetigo: Yes or No	Hernias: Normal or Abnormal	
Comments:		

Eyes	**Left**	**Right**	**Comments**
Distant Vision	20/	20/	
Light Reflex	Normal or Abnormal	Normal or Abnormal	
Accommodation Reflex	Normal or Abnormal	Normal or Abnormal	
Cataracts	Normal or Abnormal	Normal or Abnormal	
Fundi	Normal or Abnormal	Normal or Abnormal	

Bloodwork	**Date Drawn**	**Date of Results**	**Results**	**Comments**
HIV			Negative or Positive	
Hepatitis B surface antigen			Negative or Positive	
Hepatitis C antibody			Negative or Positive	

PHYSICIAN PLEASE CHECK ONE:

☐ **I have** ☐ **I have not medically cleared _____ to engage in combative sports.**

(Name)

Physician Information:

Examiner Name (Printed): _____ Title (M.D., D.O., P.A.) & Lic #: _____

Address: _____ Phone: _____

Date of Exam: _____ Examiner Signature: _____