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
REFEREE LICENSE

For UCS program information visit the UCS webpage, https://dsps.wi.gov/Pages/Professions/UnarmedCombatSports/Default.aspx.

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 #.
☐ 2. Complete the certification of legal status section on this application.
☐ 3. Complete the qualifications section on this application by attaching all documents requested.
☐ 4. Read and sign the affidavit of applicant.
☐ 5. Credential fee ($15 per year) - Attach check or fill in the credit/debit card section with the appropriate amount listed below.
☐ 6. Complete and attach the medical examination report at the end of this application.

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.

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).

1. APPLICANT INFORMATION

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).

CHECK REFEREE TYPE: ☐ **Boxing** (275) ☐ **Kickboxing** (289) ☐ **Mixed Martial Arts** (268) ☐ **Muay Thai** (290)

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

Former/Maiden/Other Name(s)	**Date of Birth (mm/dd/yyyy)**
	☐☐/☐☐/☐☐☐☐

Applicant Social Security Number Your Social Security Number **must** be submitted on this application 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.	**Social Security Number** ☐☐☐-☐☐-☐☐☐☐

Address (number/street or P.O. Box)	(city)	(state)	(zip code)

Country (if not United States)	**Telephone Number (with area code)**

E-mail Address (REQUIRED)

FEES: (License fee $15 per year. Select a box below.)

☐ **$15 (One Year)** ☐ **$45 (Three Years)** ☐ **$75 (Five Years)**
☐ **$30 (Two Years)** ☐ **$60 (Four Years)**

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, online at http://dsps.wi.gov, or by email dspscombativesports@wisconsin.gov.

For Receipting Use Only (275, 289, 268, 290)

$15(1yr) $30(2 yrs) $45(3 yrs) $60(4 yrs) $75(5 yrs)

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.

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.

4. QUALIFICATIONS (Attach required documents for the license you are applying for):

An applicant for a Referee License must submit one or more of the following:

1) A certificate of completion of a referee's training program from another state, other regulating bodies such as the Association of Boxing Commissions, and other organizations that have a referee's training program certified by the Association of Boxing Commissions or another association recognized by the department.

2) A resume with 3 professional references that can verify the number of years of experience as a referee along with a log of experience.

3) A valid and current license as a referee from another state or organization.

4) A passing grade on an examination administered by the department that tests the examinee's knowledge, and successful completion of of the trial referee program.

Note: If you are not a licensed referee from another state or organization, you must obtain a passing grade on an examination administered by the Department designed to test the applicant's knowledge. An additional exam fee of $75 will be required to take the examination. Please contact the Department Exam Office at 608-267-9362 for more information.

5. 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)**
	☐☐/☐☐/☐☐☐☐

Complete payment information on next page.

Wisconsin Department of Safety and Professional Services

5. Credential Fee (nonrefundable): (Choose the length of your credential. Must match fee box checked on bottom of Page 1):

☐ **$15.00 (one year)** ☐ **$30.00 (two years)** ☐ **$45.00 (three years)** ☐ **$60.00 (four years)** ☐ **$75.00 (five years)**

- **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: (If unable to provide a digital signature print and sign form.)

Wisconsin Department of Safety and Professional Services

6. Referee Medical Examination Report:

Your physician should complete this form in its entirety. This completed form must be submitted with the application.

Applicant's Full Name	Date of Birth
	☐☐/☐☐/☐☐☐☐

For all referee's (Please answer all of the following)

1. Any illness or injuries since last examination or within last 5 years? ☐**Yes** ☐**No**
2. Has this patient ever had severe headaches, fainting spells, or dizziness? ☐**Yes** ☐**No**
3. List any physical condition or past illness which might affect this patient's ability to perform the job. (Attach separate sheet)

Vitals	Result	Description
Pulse		
Temp		
Weight		
Height		
Blood Pressure		

Eyes (ALL REQUIRED)	Right	Left	Description
*Distant Vision	20/	20/	
*Light Reflex	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal	
*Accommodation Reflex	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal	
*Fundi	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal	
*Cataracts	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal	

Tendon Reflexes	Right	Left	Description
Knee Jerk	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal	
Babinski	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal	
Rhomberg	☐ Normal ☐ Abnormal		
Finger to Nose	☐ Normal ☐ Abnormal		

Upper Extremities		Description
Hands	☐ Normal ☐ Abnormal	
Wrist	☐ Normal ☐ Abnormal	
Elbows	☐ Normal ☐ Abnormal	
Shoulder Girdle	☐ Normal ☐ Abnormal	

Misc		Description
Lower Extremities	☐ Normal ☐ Abnormal	
Mouth and Pharynx	☐ Normal ☐ Abnormal	
Adenopathy	☐ Normal ☐ Abnormal	
Lungs	☐ Normal ☐ Abnormal	
Heart	☐ Normal ☐ Abnormal	
Abdominal Palpation	☐ Normal ☐ Abnormal	
Testis	☐ Normal ☐ Abnormal	
Hernias	☐ Normal ☐ Abnormal	
Boils, Herpes, Impetigo	☐ Yes ☐ No	

Physician/Examiner Name	Title (M.D., D.O., P.A.)	Physician/Examiner License Number
Address		**Phone Number (with area code)**
Signature (If unable to provide a digital signature print and sign form.)		**Date**
		☐☐/☐☐/☐☐☐☐