Wisconsin Department of Safety and Professional Services (DSPS)
CONTESTANT MEDICAL EXAMINATION REPORT

Upload completed form (including eye exam) into LicensE application. Proof of blood test results also required. Upload into your LicensE application.

NAME		**Date of Birth** (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

Please answer the following questions. Attach 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 below:**	☐ Yes ☐ No
3.	Have you ever had severe headaches, fainting spells, or dizziness? **If yes, describe below:**	☐ Yes ☐ No
4.	Do you have any medical conditions that may affect your ability to compete? **If yes, describe below:**	☐ Yes ☐ No
5.	What is the date of your last bout? (mm/dd/yyyy) __ __ / __ __ / __ __ __ __ **List your record below:**	
	Amateur: Wins ____ Losses ____ Draws ____ **Professional:** Wins ____ Losses ____ Draws ____	
6.	Have you ever been injured in a bout? **If yes, describe the injury or injuries below:**	☐ Yes ☐ No
7.	Have you ever been knocked out? **If yes, answer the following questions below:**	☐ Yes ☐ No
	A) Date of last knock out? (mm/dd/yyyy) __ __ / __ __ / __ __ __ __ **B) How long were you unconscious?** _____	

IMPORTANT NOTE: Your physician/physician assistant must complete the remainder of this form in its entirety. This completed form and proof of blood test results must be uploaded into your LicensE application.

VITALS	**Height**	**Weight**	**Temperature**
	Pulse	**BloodPressure**	
	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
	Wrists ☐ Normal ☐ Abnormal	**Shoulders** ☐ Normal ☐ Abnormal	**Knees** ☐ Normal ☐ Abnormal
	Ankles ☐ Normal ☐ Abnormal	**Hips** ☐ Normal ☐ Abnormal	**Comments**
MISC	**Mouth/Pharynx** ☐ Normal ☐ Abnormal	**Adenopathy** ☐ Normal ☐ Abnormal	
	Abdominal Palpation ☐ Normal ☐ Abnormal	**Boil,Herpes,Impetigo** ☐ Yes ☐ No	
	Lungs ☐ Normal ☐ Abnormal	**Hernias** ☐ Normal ☐ Abnormal	**Heart** ☐ Normal ☐ Abnormal
	Testis ☐ Normal ☐ Abnormal ☐ N/A (female)	**Comments**	

EYES (*REQUIRED - not dilated)	**Left Eye**	**Right Eye**	**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 - CHECK ONE ☐ **I HAVE** ☐ **I HAVE NOT** **Medically cleared this contestant to engage in combat sports.**	**PHYSICIAN STAMP**

Physician/Physician Assistant Name (Printed):	**Title** (MD, DO, PA)	**License Number**
Address (Number, Street, City, State, Zip Code)		**Phone Number** (with area code)
Date of Exam (mm/dd/yyyy)	**Examiner Signature** (Provide a digital signature or print and sign form.)	
__ __ / __ __ / __ __ __ __		