

Michigan Department of Licensing and Regulatory Affairs
 Bureau of Commercial Services
 Licensing Division
 UNARMED COMBAT COMMISSION
 P.O. Box 30018, Lansing, MI 48909
 517-241-8205
 www.michigan.gov/ucc

FOR OFFICE USE ONLY	
Approved By:	Date Approved:
License Number:	Dated Issued:

APPLICATION FOR RING OFFICIAL'S LICENSE

AUTHORITY: P.A. 403 of 2004
 COMPLETION: Mandatory
 PENALTY: Failure to complete may result in denial of your application

FEES

Physician	\$180.00	Nurse Practitioner	\$100.00
Physician Relicensure	\$200.00	Nurse Practitioner Relicensure	\$120.00
Physician Assistant	\$100.00		
Physician Assistant Relicensure	\$120.00		

Print in ink or type all responses below. Complete this form carefully noting the information necessary for your particular type of license.

Applicant's Name (Last, First, Middle)		Social Security Number	Date of Birth
Mailing Address (Number and Street)		City	
State	Zip Code	Home Telephone Number ()	Business Telephone Number ()

Check type of license applying for and provide your active Michigan Department of Community Health License Number:

Physician License #: _____
 Nurse Practitioner License #: _____
 Physician Assistant License #: _____

Have you ever had disciplinary action taken against any license, registration, certificate or permit you now hold or have ever held? (Includes but is not limited to final orders, suspension, revocation, denial, cease and desist order, etc.)

Yes - Download the form BCS/LCE-021 "Request for Disciplinary Action Information". The form can be downloaded and completed to accompany this application. See www.michigan.gov/ucc and select Forms & Publications. The form must be included to avoid delays in processing your application.
 No

Applicant's Certification:

I hereby certify that the statements in this application are true and correct. I have not withheld information which might affect the decisions to be made on this application. I hereby authorize the Department of Licensing and Regulatory Affairs and its agents to investigate any statements made by me in this application, including checking criminal, civil and administrative records.

I hereby acknowledge that issuance of an unarmed combat physician, physician assistant or nurse practitioner's license is a privilege. I have the responsibility to prove my general suitability, character, integrity and ability to participate, engage in or be associated with boxing and mixed martial arts contests or exhibitions. I accept the risk of adverse public notice, embarrassment, criticism, financial loss or other action with respect to this application and expressly waive any claim for damages as a result thereof.

Applicant's Signature _____ Date _____

FEE PAYMENT INFORMATION (Check One)

<input type="checkbox"/> Physician	Fee: \$180.00	(1507-01=\$ 30.00) (1507-07=\$150.00)
<input type="checkbox"/> Physician Relicensure	Fee: \$200.00	(1507-01=\$ 30.00) (1507-07=\$150.00) (1507-23=\$ 20.00)
<input type="checkbox"/> Physician Assistant	Fee: \$100.00	(1508-01=\$ 30.00) (1508-07=\$ 70.00)
<input type="checkbox"/> Physician Assistant Relicensure	Fee: \$120.00	(1508-01=\$ 30.00) (1508-07=\$ 70.00) (1508-23=\$ 20.00)
<input type="checkbox"/> Nurse Practitioner	Fee: \$100.00	(1509-01=\$ 30.00) (1509-07=\$ 70.00)
<input type="checkbox"/> Nurse Practitioner Relicensure	Fee: \$120.00	(1509-01=\$ 30.00) (1509-07=\$ 70.00) (1509-23=\$ 20.00)

FOR OFFICE USE ONLY - VALIDATION

Make your check or money order in U.S. Currency payable to:

STATE OF MICHIGAN