

Department of Energy, Labor & Economic Growth
Michigan Unarmed Combat
2501 Woodlake Circle
Okemos, MI 48864
517-241-8205

PRELICENSURE PHYSICAL EXAMINATION REPORT

MALE

FEMALE

Name (Last, First, Middle)		Ring Name	
Address: (Number and Street)	City	State	Zip Code
Date of Birth	Age	Social Security Number	

PHYSICAL HISTORY: Has the applicant ever had any of the following conditions:

- Fainting spells Rupture (hernia) Chest Pains Operations Diabetes
- Shortness of breath Swollen Joints Chronic cough Rheumatism Bleeding Disorder
- Frequent Headaches Spitting Blood Convulsions (Fits) Cerebral Hemorrhage or any other serious head injury

Amateur Record: Wins _____ Losses _____ Draws _____
Professional Record: Wins _____ Losses _____ Draws _____

PHYSICAL EXAMINATION:

General Appearance _____ Height _____ Weight _____ Temperature _____
Disabling Scars _____ Mouth _____ Teeth _____ Tonsils _____ Neck _____
Pulse at Rest _____ Blood pressure at rest _____
Pulse after 100 hops _____ Blood pressure after 100 hops _____
Enlarged Glands Yes No Goiter: Yes No Blood pressure 2 minutes after hops _____

Heart:

Electrocardiogram DATE: ____/____/____ Remarks: _____
Pulse Rhythm Regular Irregular Apical Impulse Heavy Normal
Enlargement Yes No Murmurs Yes No

Lungs: Rales Yes No

Breasts Mass Yes No Tenderness Yes No Discharge Yes No

Gynecological Examination: Yes No Remarks: _____

Testicles: Normal Yes No Remarks: _____

Abdomen Enlargement of liver Yes No

Hernia Yes No

Pelvic Normal Yes No Remarks: _____

Reflexes Pupils: _____ Knee Jerks _____ Romberg _____ Babinski _____

Skin: Rash: _____ Boils _____ Other unhealed wounds: _____

1. Urinalysis Date _____ Remarks: _____

2. Blood Count: _____ Remarks: _____

3. Bleeding and Coagulation Time _____ Remarks: _____

EYE HISTORY:

- (1) Blurred Vision? Yes No
- (2) Surgical procedures done to either of their eyes or the tissue around the eyes other than simple sutures of the skin and around the eyes? Yes No
- (3) Has the applicant ever been informed by any physician that they had significant eye problems such as retinal detachment, retinal tear, primary or secondary glaucoma, aphakia, pseudophakia, dislocated lens or cataract? Yes No

EYE EXAMINATION:

Vision without glasses: Right _____ Left _____
 Vision with glasses: Right _____ Left _____ Vision Fields: Right _____ Left _____

YOU MUST ALSO GO TO AN OPHTHALMOLOGIST FOR A DILATED EYE EXAMINATION

EXAMINING PHYSICIAN: The following section must be completed.

I have evaluated the attached CT or MRI Brain Scan, without contrast performed within the last 3 years. Yes No

CT or MRI date: ____ / ____ / ____

Remarks: _____

EXAMINING PHYSICIAN: The following section must be completed.

I have evaluated the above named contestant and/or license applicant and ordered the requested exams. Listed are any significant abnormalities either in my physical or the testing. Also listed are the steps I took to clarify any problem.

PLEASE CHECK ONE: I HAVE I HAVE NOT

MEDICALLY CLEARED ABOVE NAMED CONTESTANT AND/OR LICENSE APPLICANT TO FIGHT

PRINT Licensed Physician's Name

License Number

Physician's Signature

Date

Street Address

City

State

Zip Code

() _____

Telephone Number

APPLICANT:

I declare under penalty of perjury under the laws of the State of Michigan that the foregoing information is true and correct; further I realize that any intentional misrepresentation may result in disciplinary action against my license.

I hereby **AUTHORIZE** the Michigan Unarmed Combat Commission and or any physician employed by the Michigan Unarmed Combat Commission to **RELEASE** any and all medical information and/or personal information with respect to my status and licensure as a professional contestant which may contain any of the Commission's records. I further authorize the commission to **RELEASE** this information to any person who the commission determines has a need to know. I **AGREE** that I will fully cooperate with the Commission in making my medical history available including but not limited to giving oral or written reports to the Commission regarding my medical condition, care and/or treatment.

I further **RELEASE, PROMISE TO HOLD HARMLESS, AND CONVENANT NOT TO SUE** the Commission or any representatives of the Michigan Unarmed Combat Commission on the basis of its disclosure. I have signed the release voluntarily and of my own free will. I further agree that a photographic copy of this **AUTHORIZATION** shall be valid as the original.

Name Printed

Signature of Applicant

Date

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Michigan Unarmed Combat
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Okemos, MI 48864
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OPHTHALMOLOGICAL EYE EXAM
TO BE PERFORMED WITH DILATION AND BY AN OPHTHALMOLOGIST ONLY

Name: (Last, First, Middle)		Ring Name:	
Address: (Number and Street)	City	State	Zip Code
Date of Birth	Age	Social Security Number	Date of Exam

HISTORY: HAS APPLICANT HAD ANY OF THE FOLLOWING CONDITIONS?

- (1) Blurred Vision? Yes No
- (2) Surgical Procedures done to either of their eyes or the tissue around the eyes other than simple sutures of the skin and around the eyes?
 Yes No
- (3) Has the applicant ever been informed by any physician that they had significant eye problems such as retinal detachment, retinal tear, primary or secondary glaucoma, aphakia, pseudophakia, dislocated lenses or cataract? Yes No

If YES, please explain _____

- (4) Eye Disease? Yes No
- (5) Eye Injury? Yes No
- (6) Detached retina surgery on either eye? Yes No

List which eye and where and when surgery was performed: _____

EXAMINATION:

VISION: Without	With Glasses	REFRACTION: If either eye is 20/40 or worse
Right _____	_____	Right _____ Sph _____ Cyl x _____ Acuity _____
Left _____	_____	Left _____ Sph _____ Cyl x _____ Acuity _____
Remarks _____	Intraocular Tension: Right _____ mmHG	Left _____ mmHG
_____	Motility Normal _____ Abnormal _____	
_____	Binocular Vision Normal _____ Abnormal _____	

SLIT LAMP EXAM	NORMAL		ABNORMAL		SPECIFY ABNORMALITIES
	Right	Left	Right	Left	
Conjunctive Cornea _____	_____	_____	_____	_____	_____
Iris/Pupil _____	_____	_____	_____	_____	_____
Lens _____	_____	_____	_____	_____	_____
Eyelids _____	_____	_____	_____	_____	_____

INDIRECT OPHTHALMOSCOPY WITH SCLERAL DEPRESSION (Dilated pupil)

	NORMAL		ABNORMAL		SPECIFY ABNORMALITIES
	Right	Left	Right	Left	
Disc _____	_____	_____	_____	_____	_____
Macula _____	_____	_____	_____	_____	_____
Vessels _____	_____	_____	_____	_____	_____
Peripheral Retina _____	_____	_____	_____	_____	_____

PHYSICIAN'S REMARKS _____

PHYSICIAN:

PLEASE CHECK ONE: I DO NOT FIND I DO FIND

A CONDITION THAT WOULD PRECLUDE THE ABOVE NAMED CONTESTANT and/or LICENSE APPLICANT TO PARTICIPATE IN BOXING OR MIXED MARTIAL ARTS EVENT(S)

PRINT Licensed Physician's Name

License Number

Physician's Signature

Date

Street Address

City

State

Zip Code

()

Telephone Number

APPLICANT:

I declare under penalty of perjury under the laws of the State of Michigan that the foregoing information is true and correct; further I realize that any intentional misrepresentation may result in disciplinary action against my license.

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Name Printed

Signature of Applicant

Date