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OFFICE OF
COMBATIVE SPORTS

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PHYSICAL AND NEUROLOGICAL EXAMININATION
ONLY A LICENSED MD OR OD MAY CONDUCT THIS EXAMINATION AND COMPLETE THIS FORM.
PLEASE COMPLETE THIS FORM IN ITS ENTIRETY.

APPLICANT INFORMATION

Last Name _____ First Name _____ Middle Name _____ Date of Birth _____

PHYSICAL EXAMINATION

Your physician must complete the remainder of this form in its entirety.

Height: _____ Weight: _____ Temp: _____ □ Afebrile RR: _____ BP: _____/_____ HR: _____

		Normal	Abnormal
General		□	□
HEENT	Head	□	□
	PERRLA/EOMI	□	□
	Periorbital Regions	□	□
	Ears/Hearing (grossly)	□	□
	Jaw/Oropharynx/Teeth	□	□
	Nose (stability, obstruction)	□	□
	Lymph Nodes	□	□
	Neck	□	□
Vision	PERRLA/EOMI	□	□
	Peripheral/Fields (grossly)	□	□
Heart	Rhythm/Sounds/Murmurs	□	□
Chest	Lungs	□	□
	Ribs	□	□

		Normal	Abnormal	Deferred
Abd.	(Hernias)	□	□	□
	(Masses/Tenderness)	□	□	
Ext.	Extremities	□	□	
	Hands/Wrists	□	□	
	Knuckle Push-ups	□	□	
	Duck/Crab walk	□	□	
Skin	(Rashes/Lacerations)	□	□	
Neuro.	Alertness/Orientation	□	□	
	Cranial Nerves (grossly)	□	□	
	Tandem Gait	□	□	
	Romberg/Pronator Drift	□	□	
	Finger to Nose	□	□	
	Reflexes	□	□	
	Other: _____	□	□	

Abnormalities: _____

MEDICAL TESTING (All test results must be attached separately):

	Normal	Positive	Not Reviewed	Not Required	Date of test/exam
Hepatitis B Surface Antigen	□	□	□	□	_____/_____/_____
Hepatitis C Antibody	□	□	□	□	_____/_____/_____
HIV Antibody or Quantitative RNA (circle)	□	□	□	□	_____/_____/_____
CT Scan/MRI Brain (circle)	□	□	□	□	_____/_____/_____
EKG	□	□	□	□	_____/_____/_____
Neurological Examination	□	□	□	□	_____/_____/_____
Other: _____	□	□	□	□	_____/_____/_____

I hereby certify that based on the statements made by the participant on the reverse side of this form, my physical findings, and pending any medical testing not yet reviewed, it is my opinion that said participant is in good physical condition and

□ **IS** □ **IS NOT** medically cleared to be licensed as a competitor in professional boxing/MMA.

Reason if not cleared for competition: _____

_____

Physician's Name, M.D./D.O. _____ Signature _____ License No. _____ Date _____

Email _____ Phone _____