PETE SUAZO
UTAH ATHLETIC COMMISSION
LICENSE PHYSICAL EXAMINATION

MUST BE COMPLETED & SIGNED BY M.D. D.O. or P.A.

PSUAC
PO Box 146950
60 East South Temple
Salt Lake City, UT 84114
Office: 801-538-8607
FAX: 801-708-0849
Email: psuac@utah.gov

REQUIRED MEDICAL TESTS FOR LICENSURE OF CONTESTANTS

CONTESTANT PRELICENSE CHECKLIST

PHYSICAL EXAMINATION

☐ **LICENSE PHYSICAL**

LICENSING PHYSICALS MUST BE COMPLETED NO MORE THAN 60 DAYS PRIOR TO THE CONTEST.

(LICENSE PHYSICAL IS GOOD FOR 1 YEAR FROM THE DATE OF EXAMINATION)

Contestants 36 years and older are required to have a 12-lead EKG on file that is less than 1 year old and reviewed by a physician.

BLOOD TESTS

☐ **HIV (HUMAN IMMUNODEFICIENCY VIRUS)**

☐ **HEPATITIS B sAg (SURFACE ANTIGEN)**

☐ **HEPATITS C (HCV)**

All contestants are required to have a current HIV test (less than 6 months old), Hepatitis B sAg (Surface Antigen) and Hepatitis C tests (less than 1 year old) prior to their contest. A negative test for Hepatitis B sAg AND proof of vaccination/immunity for Hepatitis BaB will permanently fulfill the Hepatitis B requirement.

NATIONAL IDENTIFICATION CARD

☐ **FEDERAL BOXING ID CARD**

(NEW BOXING CONTESTANT MUST OBTAIN THEIR FEDERAL IDENTIFICATION FROM THEIR HOME STATE BOXING COMMISSION IN ADVANCE (ID CARDS EXPIRE AFTER 4 YEARS FROM THE DATE OF ISSUANCE)

☐ **MIXED MARTIAL ARTS NATIONAL ID**

NEW MIXED MARTIAL ARTS CONTESTANTS MUST OBTAIN THEIR FEDERAL IDENTIFICATION CARD FROM THEIR HOME STATE BOXING COMMISSION or THE PETE SUAZO UTAH ATHLETIC COMMISSION CAN ISSUE IT.
(ID CARDS EXPIRE AFTER 5 YEARS FROM THE DATE OF ISSUANCE)

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{ ALL REQUIRED }

NAME (LAST, FIRST, MIDDLE)				DATE OF EXAM	
ADDRESS	CITY	STATE	ZIP CODE		
TELEPHONE NUMBER	EMAIL ADDRESS	SOCIAL SECURITY NUMBER {Required}			
HAIR COLOR	EYE COLOR	TATTOOS/ SCARS	DATE OF BIRTH	AGE	SEX (Circle) M F

MEDICAL HISTORY (PLEASE COMPLETE AS THOUGHLY AS POSSIBLE BY ATHLETE)

A. HAS APPLICANT EVER HAD ANY OF THE FOLLOWING CONDITIONS, PLACE AN "X" TO ALL THAT APPLY

☐ Fainting Spells ☐ Rupture (hernia) ☐ Chest Pain ☐ Operations ☐ Shortness of Breath ☐ Swollen Joints ☐ Rheumatism ☐ Diabetes
☐ Headaches ☐ Seizures/Convulsions ☐ Chronic Cough ☐ Bleeding Disorder ☐ Spinal Injuries ☐ Cerebral Hemorrhage or head injury
☐ Psychiatric problems ☐ Neck Injuries ☐ Vision Problems ☐ Asthma ☐ Allergies ☐ Skin Disease ☐ Heart Palpitations

1. HAVE YOU EVER BEEN HOSPITALIZED?
☐ Yes ☐ No If "yes", give nature of problem(s), date(s), locations(s) and attending physicians:

2. HAVE YOU EVER HAD EYE SURGERY?
☐ Yes ☐ No If "yes", explain:

3. DO YOU REGULARLY OR OCCASIONALLY TAKE AND MEDICATIONS? ***NOTE: SOME PRESCRIBED MEDICATIONS *MAY* BE PROHIBITED, IF "YES" CHECK WITH PSUAC OFFICIAL PRIOR TO CONTEST OR *www.USADA.org*
☐ Yes ☐ No If "yes", explain frequency & dose:

4. Are you allergic to any medications?
☐ Yes ☐ No If "yes", explain:

4. HAVE YOU BEEN PREVIOUSLY INJURED IN A BOXING/KICKBOXING OR MMA EVENT?
☐ Yes ☐ No If "yes", explain:

5. LONGEST DURATION OF UNCONSCIOUSNESS:

6. WHAT IS YOUR RECORD:	7. WHAT IS YOUR RECORD IN THE LAST YEAR:
Wins: _____ Losses: _____ Draws: _____	Wins: _____ Losses: _____ Draws: _____ Losses by TKO or KO:_____
8. WHEN WERE YOU LAST GIVEN A MEDICAL SUSPENSION? (Date)	**9. WHY WERE YOU A GIVEN A MEDICAL SUSPENSION?**

I hereby authorize the Pete Suazo Utah Athletic Commission to release, disclose and furnish to any other boxing or athletic commission affiliated with the Association of Boxing Commissions, (ABC), any and all of my medical records concerning my licensure as a participant including, but not limited to, all required medical examinations, laboratory test results for HIV, hepatitis virus and drug screening, hospital records, and the other information regarding conditions related to the propriety my licensure as a participant (Including history, findings, diagnosis, or prognosis).

I understand, and it is agreed, that the signing of the Medical Information Release is optional, and that my declining to sign the document will not result in any adverse action being taken against me by the Pete Suazo Utah Athletic Commission based on my decision. I understand, and it is agreed, that the medical record described herein will not be released for any purpose other than for a member commission affiliated the ABC to determine eligibility to participate in any professional or amateur Boxing, Kickboxing, or Mixed Martial Arts events. I understand, and it is agreed, that this authorization shall remain in effect for 18 months from the date of examination and is relevant medical records described herein, whether such record were created prior to, or subsequent to, the date the authorization is signed. By signing below, I hereby authorize the release of my medical information.

PRINT CONTESTANT NAME	CONTESTANT SIGNATURE	DATE

MEDICAL EXAM (TO BE COMPLETED BY THE DOCTOR ONLY)

HEIGHT:	WEIGHT :	TEMPATURE:	GENERAL APPEARANCE:

OTOLOGIC NOTES:
External Trauma ☐ Yes ☐ No
Perforated Drum ☐ Yes ☐ No

NOSE NOTES:
Instability ☐ Yes ☐ No
Recent Trauma ☐ Yes ☐ No
Obstruction ☐ Yes ☐ No

OROPHARYNX NOTES:
Loose Teeth ☐ Yes ☐ No

ADENOPATHY
☐ Yes ☐ No

FACE NOTES:
Recent Trauma ☐ Yes ☐ No
Jaw & Temporomandibular Joints ☐ Normal ☐ Abnormal

TESTES NOTES:
☐ Yes ☐ No

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MEDICAL EXAM CONTINUED (TO BE COMPLETED BY THE DOCTOR ONLY)

LUNGS (RALES) ☐ Normal ☐ Abnormal

ENLARGED GLANDS ☐ Yes ☐ No

GOITER ☐ Yes ☐ No

ABDOMEN **NOTES:**

Enlargement of Liver ☐ Yes ☐ No
Hernia ☐ Yes ☐ No
Enlargement of Spleen ☐ Yes ☐ No ☐ Femoral ☐ Inguinal ☐ Ventral

HEART

Pulse Rhythm ☐ Normal ☐ Abnormal ☐ Apical Impulse ☐ Heavy ☐ Normal
Enlargement ☐ Yes ☐ No ☐ Murmurs ☐ Yes ☐ No

MUSCULOSKELETEL

Hands ☐ Normal ☐ Abnormal Comments:_____

Wrists ☐ Normal ☐ Abnormal Comments:_____

Elbows ☐ Normal ☐ Abnormal Comments:_____

Shoulder Girdle ☐ Normal ☐ Abnormal Comments:_____

Lower Extremities ☐ Normal ☐ Abnormal Comments:_____

(CIRCLE) **n/a** **BREAST (FEMALE CONTESTANTS)**

Mass ☐Yes ☐No Tenderness ☐Yes ☐No Discharge ☐Yes ☐No

(CIRCLE) **n/a** **GYNECOLOGICAL EXAM (FEMALE CONTESTANTS)** **NOTES:**

☐ Normal ☐ Abnormal

REFLEXES

Pupils_____ Romberg_____ Knee Jerks_____ Babinski_____

NEUROLOGIC

Mental Status Orientation _____ /3

5-minute recall _____ /3

Cranial Nerves ☐ Normal ☐ Abnormal Strength ☐ Normal ☐ Abnormal
Tone ☐ Normal ☐ Abnormal Gait ☐ Normal ☐ Abnormal
Coordination ☐ Normal ☐ Abnormal
Finger to Nose ☐ Normal ☐ Abnormal Tandem Gait ☐ Normal ☐ Abnormal

PHYSICAL EXAMINATION

Disabling scars _____ Mouth Teeth Tonsils Neck _____

Pulse at rest Blood pressure at rest _____

Pulse after 100 hops Blood pressure after 100 hops _____

Blood pressure 2 minutes later _____

COMMENTS OF EXAMINING PHYSICIAN

I hereby certify that I have examined the named individual and in my opinion, this individual ☐ **is or** ☐ **is not** medically fit to participate as a contestant in a professional boxing, kick boxing, martial arts or other unarmed combat competition. I also attest that I do not have a professional relationship with, nor financial interest in the earnings of this individual.

MUST BE COMPLETED AND SIGNED BY M.D. D.O. or P.A. (If not completed by M.D. D.O. or P.A. it will be rejected)

PRINT NAME OF EXAMINING PHYSICIAN	PHYSICIANS LICENSE NUMBER
SIGNATURE OF EXAMINING PHYSICIAN	ADDRESS OF PHYSICIAN
TELEPHONE NUMBER OF PHYSICIAN	DATE