



PETE SUAZO
UTAH ATHLETIC COMMISSION
LICENSE PHYSICAL EXAMINATION

PSUAC
3760 S. Highland Dr.
Millcreek, UT 84106
Office: 801-538-8607
FAX: 801-708-0849
Email: psuac@utah.gov

REQUIRED MEDICAL TESTS FOR LICENSURE OF CONTESTANTS

CONTESTANT PRELICENSE CHECKLIST

THIS FORM IS FOR YOUR RECORDS ONLY. DO NOT REMIT THIS PAGE TO THE PSUAC

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)**

☐ **HEPATITIS 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 ID 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 ID CARD FROM THEIR HOME STATE BOXING COMMISSION or the PETE SUAZO UTAH ATHLETIC COMMISSION may 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							
<input type="checkbox"/> Fainting Spells <input type="checkbox"/> Rupture (hernia) <input type="checkbox"/> Chest Pain <input type="checkbox"/> Operations <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Swollen Joints <input type="checkbox"/> Rheumatism <input type="checkbox"/> Diabetes							
<input type="checkbox"/> Headaches <input type="checkbox"/> Seizures/Convulsions <input type="checkbox"/> Chronic Cough <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Spinal Injuries <input type="checkbox"/> Cerebral Hemorrhage or head injury							
<input type="checkbox"/> Psychiatric problems <input type="checkbox"/> Neck Injuries <input type="checkbox"/> Vision Problems <input type="checkbox"/> Asthma <input type="checkbox"/> Allergies <input type="checkbox"/> Skin Disease <input type="checkbox"/> Heart Palpitations							
1. HAVE YOU EVER BEEN HOSPITALIZED? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", give nature of problem(s), date(s), locations(s) and attending physicians:							
2. HAVE YOU EVER HAD EYE SURGERY? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", explain frequency & dose:							
4. Are you allergic to any medications? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", explain:							
4. HAVE YOU BEEN PREVIOUSLY INJURED IN A BOXING/KICKBOXING OR MMA EVENT? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", explain:							
5. LONGEST DURATION OF UNCONSCIOUSNESS:							
6. WHAT IS YOUR RECORD: Wins: _____ Losses: _____ Draws: _____				7. WHAT IS YOUR RECORD IN THE LAST YEAR: 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
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MEDICAL EXAM (TO BE COMPLETED BY THE DOCTOR ONLY)			
HEIGHT:	WEIGHT :	TEMPERATURE:	GENERAL APPEARANCE:
OTOLOGIC External Trauma <input type="checkbox"/> Yes <input type="checkbox"/> No Perforated Drum <input type="checkbox"/> Yes <input type="checkbox"/> No		NOSE Instability <input type="checkbox"/> Yes <input type="checkbox"/> No Recent Trauma <input type="checkbox"/> Yes <input type="checkbox"/> No Obstruction <input type="checkbox"/> Yes <input type="checkbox"/> No	
OROPHARYNX Loose Teeth <input type="checkbox"/> Yes <input type="checkbox"/> No		ADENOPATHY <input type="checkbox"/> Yes <input type="checkbox"/> No	
FACE Recent Trauma <input type="checkbox"/> Yes <input type="checkbox"/> No Jaw & Temporomandibular Joints <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		TESTES <input type="checkbox"/> Yes <input type="checkbox"/> No	



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

LUNGS (RALES) <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	ENLARGED GLANDS <input type="checkbox"/> Yes <input type="checkbox"/> No	GOITER <input type="checkbox"/> Yes <input type="checkbox"/> No
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ABDOMEN Enlargement of Liver <input type="checkbox"/> Yes <input type="checkbox"/> No Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No Enlargement of Spleen <input type="checkbox"/> Yes <input type="checkbox"/> No	NOTES: <input type="checkbox"/> Femoral <input type="checkbox"/> Inguinal <input type="checkbox"/> Ventral
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HEART Pulse Rhythm <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Apical Impulse <input type="checkbox"/> Heavy <input type="checkbox"/> Normal Enlargement <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Murmurs <input type="checkbox"/> Yes <input type="checkbox"/> No

MUSCULOSKELETAL Hands <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Comments: _____ Wrists <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Comments: _____ Elbows <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Comments: _____ Shoulder Girdle <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Comments: _____ Lower Extremities <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Comments: _____

(CIRCLE) n/a	BREAST (FEMALE CONTESTANTS) Mass <input type="checkbox"/> Yes <input type="checkbox"/> No Tenderness <input type="checkbox"/> Yes <input type="checkbox"/> No Discharge <input type="checkbox"/> Yes <input type="checkbox"/> No
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(CIRCLE) n/a	GYNECOLOGICAL EXAM (FEMALE CONTESTANTS) <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
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REFLEXES Pupils _____ Romberg _____ Knee Jerks _____ Babinski _____

NEUROLOGIC Mental Status _____ Orientation _____ /3 5-minute recall _____ /3 Cranial Nerves <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Strength <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Tone <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Gait <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Coordination <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Tandem Gait <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Finger to Nose <input type="checkbox"/> Normal <input type="checkbox"/> 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. **IF THIS IS NOT CONFIRMED THE FORM IS INCOMPLETE**

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

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