COLOR PHOTO
(passport type)

ASSOCIATION OF BOXING COMMISSIONS
MIXED MARTIAL ARTS
NATIONAL IDENTIFICATION CARD

APPLICATION FORM

ID #: _____

DATE ISSUED: _____

ISSUING COMMISSION: _____

EXP. DATE: _____

FIRST NAME: _____ LAST NAME_____MIDDLE NAME:_____

DATE OF BIRTH: ____/___/____ SOC SEC #: _____-____-_____

ADDRESS: _____ CITY: _____ STATE/PROVINCE:_____ ZIP: _____

HEIGHT: _____ WEIGHT: _____ COLOR OF HAIR: _____ COLOR OF EYES: _____

HOME PHONE: (_____) _____ E-MAIL ADDRESS: _____

BIRTHMARKS, SCARS OR TATTOO'S:_____

YEARS OF EXPERIENCE: _____

TERMS AND CONDITIONS:

1. Applicant must apply for National MMA ID Card in the state/province in which he/she is a resident.
2. National MMA ID Card will not be issued unless an accurate and truthful application form is completed in its entirety. Incomplete forms will not be accepted and will be returned to applicant for completion.
3. Two color (passport type) photos must be submitted with the completed application form.
4. Two forms of identification must be presented at the time of application and must include a color photo of the applicant. Accepted forms of identification will include, but not be limited to driver's license, passport, state/province issued identification or any other form of identification accepted by issuing Commission.
5. Applicant understands that he/she will not be allowed to compete without a National MMA ID Card.
6. Applicant understands that the ABC in cooperation with the issuing Commission will settle any and all disputes with regards to violations of these terms and conditions for the National MMA ID Card. The ruling of the ABC is final and binding on all parties.
7. Applicant agrees to abide by these and any other terms and conditions, rules and regulations set forth by the ABC and the issuing Commission.
8. Applicant understands and agrees that the ABC reserves the right to amend the terms and conditions for issuing the National MMA ID Card.

I certify that I have read and understand the terms and conditions pertaining to the application for a National MMA ID Card, that all information given is my own, is true and correct to the best of my knowledge. I further understand and agree that any false, misstatements or incomplete information on the application will constitute grounds for revoking or denial of the National MMA ID Card, and subject me to a one year suspension at the discretion of the ABC or issuing Commission.

_____ _____ _____ _____
Applicant's Signature Date Commission Representative Date

revised: 09/29/2008

OSOC-103-1-73
(REV. 12/96)

PA DEPARTMENT OF STATE
STATE ATHLETIC COMMISSION
2601 North 3rd Street
Harrisburg, PA 17110
Phone 717-787-5720
Fax 717-783-0824

COMMONWEALTH OF PENNSYLVANIA

APPLICATION FOR BOXER–MMA-Professional

LICENSE
Fee $22.00

DATE :_____

LICENSE NO. _____

FEDERAL I.D. #_____

READ INSTRUCTIONS CAREFULLY

Two photographs must accompany application.
Payment must be made by check or money order made payable to the Commonwealth of Pennsylvania.
Send to: State Athletic Commission
2601 North 3rd Street
Harrisburg, PA 17110

EACH APPLICANT SHOULD ANSWER THE FOLLOWING

PLEASE PRINT CLEARLY SOCIAL SECURITY NO. _____

Name of Applicant _____
(LAST) (FIRST) (PHONE NO.)

Address _____
(NUMBER AND STREET) (CITY) (STATE) (ZIP CODE)

Ring Name _____

Place of Birth _____ Date of Birth_____ Age _____

Boxers Current Record:____, ____, ____ Name of Gym or Club where you train: _____

Date of Last Bout: _____ Result of Last Bout:_____ Location of last Bout:_____

Occupation _____ Employer _____

Normal Weight _____ Ring Weight _____ Hair color _____ Eye Color _____

Have you ever been Arrested for Violating the Laws of Pennsylvania or any other State? _____

If YES, state Where and Give details _____

Have you been licensed before by this Commission? Yes____ No____ If YES, when? _____

Are you currently licensed by any other Athletic Commission? Yes_____ No_____

If YES, which Commissions? _____

Are you currently under any type of suspension from any commission? Yes_____ No_____

If YES, give details _____

Have you any financial interest in the promotion of professional sports in this or any other state? Yes____ No____

If yes, give details _____

Are you currently under any type of boxer/manager contract? Yes_____No_____

If YES, list name of manager_____
NAME OF MANAGER CITY/STATE WHERE CONTRACT WAS FILED

Do you have any type of Personal Service Contract? Yes____ No____

If YES, list name _____ _____
PERSON/ORGANIZATION CITY/STATE WHERE CONTRACT WAS FILED

HIV/Hep. B/C TEST

Date of last exam _____ Location of Exam _____

Is your **negative** test attached to this form? Yes____ No ____

Do you understand the HIV/AIDS Disease and the testing procedures that were done? Yes____ No____

Would you like more information about the HIV/AIDS virus? Yes____ No____

ATHLETIC COMMISSION HIV/AIDS REGULATIONS:

The PA State Athletic Commission will not accept this application unless it is accompanied by a **negative** HIV, Hepatitis B, Surface Antigen and Hepatitis C tests. These tests must have been completed within (6) months from the date on this application.

ATHLETIC COMMISSION DRUG ABUSE REGULATIONS:

The Pennsylvania State Athletic Commission may require each boxer to submit to a drug screening test through urine analysis.

If any boxer is detected to have used drugs and this is confirmed by a second drug test, the findings will be reviewed by the Commission for determination of sanctions. Note: Refusal of a drug test will result in a suspension.

****** Boxers are covered by INSURANCE while competing in this state. Ask the Commission for further details.

The undersigned hereby affirms that the statements made herein are true and correct to the best of my information, knowledge and belief. I understand that any false statement is made subject to the penalties set forth in 18 PA C. S. section 4904, relating to unsworn falsification to authorities and may also result in the suspension or revocation of my license. I do authorize the Pennsylvania Athletic Commission to release any and all of my medical records to any other state or tribal commission upon request of that commission.

By: _____
APPLICANT'S SIGNATURE

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
STATE ATHLETIC COMMISSION
2601NORTH 3rd Street
HARRISBURG, PA 17110

Gregory P. Sirb
Executive Director

Telephone: (717) 787-5720
Fax: (717) 783-0824

SUBJECT: Verification of Boxing Experience

FROM: Gregory P. Sirb, Executive Director
Pennsylvania State Athletic Commission

By signing this form below you are certifying that _____ has, in your
Name of Boxer
judgement, the necessary skills to qualify and be licensed as **a professional boxer** in this state.

You make this judgement based on the following: **(circle all that apply)**

* The above named Boxer has been training at your gym
If YES for how long _____
* Name and Location of the GYM where the Boxer has trained:

_____

* You have witnessed the above named Boxer spar and train and feel he/she is duly qualified.

* You have first-hand knowledge of the above named Boxer's amateur boxing experience
If YES please list his/her over-all amateur boxing record: _____
And include his/her amateur boxing passbook.

What if any relationship do you have with the above named boxer?

Do you hold any type of license with the Pennsylvania State Athletic Commission or any other state/tribal Commission? If YES please list the type of license and the Commission's name:

_____

Trainer's /Manager's Name _____
(Please Print)

***By signing below I also verify that the above named Boxer has NEVER competed in any professional contest in any form of contact sports.**

_____ _____
Signature **Date**

COMMONWEALTH OF PENNSYLVANIA
STATE ATHLETIC COMMISSION

PHYSICIAN'S EXAMINATION - DATE: _____

BOXER'S/MMA Fighter's NAME: _____
SS #: _____ DATE OF BIRTH: _____
AGE: _____ Federal ID#_____CURRENT WEIGHT: _____ HEIGHT_____

TO BE COMPLETED BY EXAMINING PHYSICIAN:

UNLESS STATED Indicate normal findings by placing a check (VISION must be at least **20/70-W/O Glasses**)

1. Visual Acuity: **List Actual** _____ Peripheral Vision **(DEGREES)** _____

2. Pupils: Regular _____ Equal _____ React to light _____ Anterior Segment _____

3. Periorbital Regions (describe scars, if any) _____

4. Oropharynx: _____ Ears (discharge, etc.) _____

5. Lungs: (Any abnormal breath sounds, friction rub, rales, etc.) _____

6. Heart Rate: **List Actual** _____ Any irregularity _____ Murmurs _____

7. Pulse Rate: **List Actual** _____ Blood Pressure: **List Actual** _____

8. Abdominal Exam: _____

9. Extremities (Stiffness, swelling, tenderness): **YES** _____ **NO** _____

10. Hands (fists): Any Fractures, or Swelling: **YES** _____ **NO** _____

11. Nervous System: Orientation _____ Cerebellum _____ Cranial Nerves _____

12. Nose: Instability **YES** __ **NO** _____ Obstruction **YES** __ **NO** _____

13. Coordination: Finger to Nose - Normal _____ Abnormal _____

14. Tandem Gait: Normal _____ Abnormal _____

15. **In your opinion is this individual in condition to compete as a Pro/Amateur MMA/ Boxer: YES____ NO___**
IF NO WHY _____ _____

NAME OF EXAMINING PHYSICIAN (PRINT): _____
TELEPHONE #: _____ FAX #: _____
PHYSICIAN'S SIGNATURE: _____ DATE: _____

SEND TO:
PENNSYLVANIA STATE ATHLETIC COMMISSION
2601North 3rd Street
HARRISBURG, PA 17110

TELEPHONE #: 717-787-5720
FAX #: 717-783-0824

Commonwealth of Pennsylvania
Department of State
State Athletic Commission

NEUROLOGICAL EXAMINATION REPORT

Only a licensed physician who specializes in neurology or neurosurgery may conduct this examination and complete this form. Please complete this form in its entirety.

Fighters Name _____ **Date of Birth**

Date of the NEURO EXAM = _____

NEUROLOGICAL EXAMINATION

CRANIAL NERVES (1 – 5)

1. **Pupillary size in MM OD** _____ **OS** _____ ***Reactivity*** **OD** _____ **OS** _____
   Note any asymmetry _____
2. **Fundus** **OD** _____ **OS** _____
3. **Eye closure** _____
4. **Extraocular motility** visual pursuit _____ saccades _____ nystagmus _____
   Describe any abnormality _____
5. **Palate elevation**

MOTOR (6 – 9)

6. **Strength** **RUE** _____ **LUE** _____ **FILE** _____ **LLE** _____
   List any abnormality _____
7. **Tone** **RUE** _____ **LUE** _____ **FILE** _____ **LLE** _____
   (I = increased D = decreased N = normal)
8. **Range of motion** **RUE** _____ **LUE** _____ **FILE** _____ **LLE** _____
   Describe reason for restriction _____
9. **Abnormal movements** (tics, chorea, choreiform, myoclonus, etc.) _____
   Fasciulations _____
   Describe any abnormal movements _____

CEREBELLAR (10 – 15)

10. **Finger – nose – finger** *Describe any abnormalities* _____
11. **Heel – shin** *Describe any abnormalities* _____
    Abnormal = 3 failures
12. **Rebound check** *Describe any abnormalities* _____
    Abnormal =2 failures
13. **Rapid alternating hand movements**
    Describe any abnormalities _____
14. **One foot hop (3 trails, 5 secs ea ft)**
    Describe any abnormalities _____
15. **Romberg** *Describe any abnormalities* _____

NEUROLOGICAL EXAMINATION

APPLICANT NAME: _____

GAIT (16)

16. Gait

Routine Gait _____ Heal Walk _____ Toe Walk _____ Tandem Walk _____

Note any abnormal movements, including upper extremity (ie: dystonic posturing, athetosis)

_____ **N/A _____(16)**

SENSATION (17)

17. Sensation _____ **N/A ____(17)**

DEEP TENDON REFLEXES (18 – 19)

18. Deep Tendon Reflexes _____ **N/A _____(18)**

19. Babinski _____ **N/A _____(19)**

OTHER OBSERVATIONS (20)

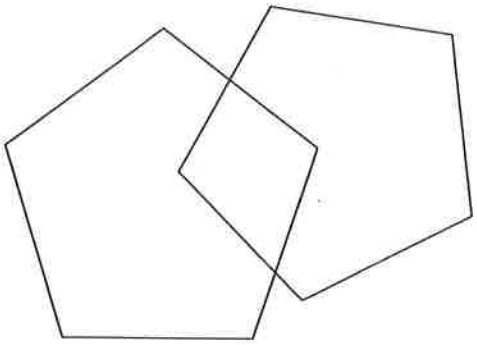
20. List any other symptoms or evidence of neurological abnormalities from history or observations.

_____ **N/A _____(20)**

MENTAL STATUS EXAMINATION

MINI-MENTAL STATUS EXAM (1 - 9)

		Maximum Score	Score
1.	What is the (year) (season) (date) (month)	5	_____
2.	Where are we (state) (county) (city) (hospital) (floor)	5	_____
3.	Name 3 objects: (e.g., cow, apple, bus) – one second to say each Then ask applicant all three after you have said them. (One point for each correct answer.) Then repeat them until he/she learns all 3. Count trials and record. Trials = _____	3	_____
4.	Serial 7's. (One point for each correct.) Stop after 5 attempts	5	_____
5.	Ask for the 3 objects repeated above (one point for each correct)	3	_____
6.	Name a pencil and a watch	2	_____
7.	Repeat: "NO IFS, ANDS, OR BUTS"	1	_____
8.	Follow a 3-stage command: "TAKE A PAPER IN YOUR RIGHT HAND. FOLD IT IN HALF, AND PUT IT ON THE FLOOR"	3	_____
9.	Copy Design	1	_____



TOTAL SCORE _____

(0-21 suggests cognitive impairment) **N/A____(1-9)**

EXAMINING NEUROLOGIST OR NEUROSURGEON

As a licensed physician specializing in neurology or neurosurgery *(circle one)*, I DO or DO NOT *(circle one)* believe that this applicant could be permitted to be licensed as a Pro/Amateur Fighter in Pennsylvania.

Is further referral necessary? _____

Are additional exams needed? _____

I certify under penalty of perjury under the laws of the State of Pennsylvania that I am a licensed physician and that I specialize in neurology or neurosurgery.

_____ _____

Licensed Neurosurgeon or Neurologist's Name (Print) Medical License Number

_____ _____

Signature of Neurosurgeon or Neurologist Date

_____

(Street Address) City State Zip Code

Office Phone # = _____

COMMONWEALTH OF PENNSYLVANIA
DEPARMENT OF STATE
STATE ATHLETIC COMMISSION
2601 North 3rd Street
Harrisburg, PA 17110

OPHTHALMIC EXAM

History: (To be completed by the **BOXER.**)

Do you have any history of:	YES	NO
Decreased vision	_____	_____
Loss of vision	_____	_____
Double vision	_____	_____
Amblyopia (lazy eye)	_____	_____
Crossed eyes	_____	_____
Eye or orbital injury	_____	_____
Light flashes and/or floating spots	_____	_____
Any other ocular or orbital condition	_____	_____

Explain any yes answers here:

The forgoing information is true and complete to the best of my knowledge, and I confirm this statement under penalty of perjury.

_____	_____	_____
Date	Boxer's Name (Print)	Boxer's Signature

VISUAL REQUIREMENTS FOR LICENSURE BY THE PENNSYLVANIA STATE ATHLETIC COMMISSION:

a) Uncorrected visual acuity: 20/200 or better in each eye
b) Corrected visual acuity: 20/40 or better in each eye
c) Normal visual field
d) Absence of "Major Ocular Pathology"
    1) Anterior Chamber Angle Abnormalities
    2) Glaucoma or Suspicion of Glaucoma
    3) Lens Abnormalities
    4) Peripheral Retinal Abnormalities
    5) Macular Abnormalities
    6) Diplopia or Extraocular Muscle Palsy
    7) Active Inflammation
    8) Optic Nerve Abnormalities

OPHTHALMIC EXAM
(To be completed by an OPHTHALMOLOGIST ONLY)

_____
Patient's Name

VISUAL ACUITY	RIGHT	LEFT
Without Correction	_____	_____
With Correction	_____	_____
VISUAL FIELD	_____	_____
EXTERNAL EXAM	_____	_____
ANTERIOR SEGMENT EXAM	_____	_____
DILATED RETINAL EXAM	_____	_____
OPTIC NERVE	_____	_____
EXTRAOCULAR MUSCLES	_____	_____
GONIOSCOPY (Angle Recession)	_____	_____
INTRAOCULAR PRESSURE	_____	_____

PLEASE COMMENT ON ANY AND ALL ABNORMAL FINDINGS:

IMPRESSION AND ADDITIONAL COMMENTS (Add extra page if necessary)

ALLOW TO BOX 1) YES_____ 2) CONDITIONAL_____ 3) NO_____

_____ _____ _____
Physician's Signature Print Name Date

_____
Street Address

_____
City State Zip Phone

FAX OR MAIL TO:

PENNSYLVANIA STATE ATHLETIC COMMISSION
2601 NORTH 3RD ST
HARRISBURG PA 17110

PHONE: 717-787-5720
FAX: 717-783-0824