



PETE SUAZO
UTAH ATHLETIC COMMISSION
LICENSE PHYSICAL EXAMINATION

**MUST BE COMPLETED &
SIGNED BY M.D. or D. O.**

PSUAC
PO Box 146950
60 East South Temple
Salt Lake City, UT 84114
Office: 801-538-8876
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)

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 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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NAME (LAST, FIRST, MIDDLE)				DATE OF EXAM	
ADDRESS		CITY		STATE	
TELEPHONE NUMBER		EMAIL ADDRESS		SOCIAL SECURITY NUMBER	
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 ANY 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 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:	TEMPATURE:	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 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

MUSCULOSKELETAL

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 <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) NOTES: <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 Normal Abnormal Strength Normal Abnormal
 Tone Normal Abnormal Gait Normal Abnormal
 Coordination Normal Abnormal Tandem Gait Normal Abnormal
 Finger to Nose 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. OR D.O. (If not completed by M.D. or D.O. it may be rejected)

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