STATE ATHLETIC COMMISSION
Idaho Division of Occupational and Professional Licenses
11341 W. Chinden Blvd., Bldg. #4, Boise ID 83714 or
P.O. Box 83720, Boise ID 83720-0063
Phone: (208) 334-3233 Website: https://dopl.idaho.gov
E-mail: atc@dopl.idaho.gov

APPLICATION FOR LICENSURE AS A COMBATANT

CHECKLIST

All items on this list **must** be completed or submitted prior to any scheduled event. This page is for your use to keep track of what is required for licensure as an amateur or professional combatant in the state of Idaho. **Incomplete applications cannot be processed. Attempts to submit applications missing necessary documents will result in delays in licensure.**

☐ **Completed Application Form**

-This includes *both* pages of the form, all personal information, questions, and a notarized signature

☐ **Full Physical Performed in the Past 12 months**

-Must be performed by a licensed physician

-Applicants should utilize the attached form, but any submitted physical must be dated, signed by the physician, and fully describe the health of the applicant and their fitness for competition

☐ **Bloodwork Collected Within the Past 6 months**

-Must be dated and show negative for HIV, Hepatitis B surface antigen (HBsAg), and Hepatitis C

☐ **5-Panel Drug Test Performed in the Past 6 months**

-Must be dated and show negative for illegal substances

☐ **HIPPA Release Form**

-Instructs the Commission on how you would like your medical information and records handled

☐ **$150/$100 Application Fee**

-If submitting by mail, include a check or money order made out to 'Idaho Division of Occupational and Professional Licenses' or 'DOPL'

-Credit Card payments are accepted at our main office

Please ensure that your application includes all these items before you submit. Physical, bloodwork, and 5-Panel results may be submitted via email to atc@dopl.idaho.gov.

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APPLICATION FOR LICENSURE AS A COMBATANT

I hereby make application for licensure in the State of Idaho under the provisions of Title 54, Chapter 4, Idaho Code as amended as follows: (please check only **ONE TYPE & ONE CLASS**. Separate applications are required for each type & class and attach a check or money order made out to the DOPL) **$150 (Amateur $100)**

TYPE:

( ) Boxing ( ) Professional Wrestling ( ) Mixed Martial Arts

CLASS:

( ) Professional ( ) Amateur

1. **Full Name** ____

   1a. If the applicant is under the age of eighteen, name of parent or guardian: ______________________

2. **Address of Record** ____
   (The above address is public record) Street City State Zip

3. **Mailing Address** ____
   (The above address is not public record) Street/PO Box City State Zip

4. **Social Security No.** _____-____-______ **Date of Birth** ____ /_____/ _______
   (This is not a public record; required by I.C. § 73-122) MM DD YYYY (Proof of identification – a clear and readable copy of a government-issued photo ID such as a passport, military ID, or valid driver's license must be attached.)

5. **Business Phone (____)**___________ **Cell Phone**______________ **E-mail** ______________________
   (The above phone number is public record) (The above phone number is not public record) (This is not a public record; required by I.C. § 67-2609.)

6. **Are you or your spouse an active member or honorably discharged veteran of the United States Armed Services?** **( ) Yes ( ) No**
   (To utilize experience or education gained in the military to qualify you for this license/registration, please attach a copy of your DD-214.)

7. **Have you ever been convicted, pled guilty, or nolo contendere for any State or Federal felony?**
   (If yes, the Criminal Conviction Disclosure Form, official court documents, and probation and parole documents along with any other relevant information must be received with this application.) **( ) Yes ( ) No**

8. **Within the past two years have you received a conviction for a drug-related misdemeanor or felony?** (If yes, please attach a copy of the charges, the final order, and answer questions 8a. and 8b below.) **( ) Yes ( ) No**

   8a. Since the conviction, have you successfully completed a drug rehabilitation program?
   (If yes, please identify the program and provide documentation showing when you completed the program.) **( ) Yes ( ) No**

8b. If you have not successfully completed a drug rehabilitation program since your conviction, please obtain a urinalysis no more than one week prior to the submission of this application and have the results delivered directly to the Commission. The results must show that you are negative for illegal drugs and substances. (Including controlled substances for which you lack a prescription) **( )Done ( ) Not Done**

9. **Have you ever had a license or registration revoked, suspended, or otherwise sanctioned?** **( ) Yes ( ) No**
   (If yes, a copy of the charges and the final order must be received before your application is processed.)

10. **Are you or have you ever been a user of or addicted to any habit forming or unlawful substance?** **( ) Yes ( ) No**
    (If yes, or the result of your urinalysis is positive, you must attach proof of participation in a recognized drug rehabilitation program.)

11. **Within the six (6) months immediately preceding this application, have you obtained a blood test that demonstrates that your blood tested negative for HIV, Hepatitis B surface antigen and Hepatitis C antibody, and illegal drugs and substances?** (Including controlled substances for which you lack a prescription) **( ) Yes ( ) No**
(Please attach a copy of the results.)

NOTE: A combatant must submit to a blood test within six (6) months preceding each event in which he will compete if such event occurs more than six (6) months after the date of the blood test that accompanies this application.

Amateur boxing OR martial arts record:

Wins: _______ Wins by KO/TKO: _______

Losses: ______Losses by KO/TKO: _______

AFFIDAVIT

I hereby affirm that I am the person named above and that I have no infectious or contagious disease which may pose a threat to the public. I affirm that the information provided on and attached to this application is true and accurate to the best of my knowledge and belief. I further certify that I will comply with the Idaho Laws and Rules governing the license for which this application is being submitted. I also hereby authorize and direct any person, agency, firm, or other entity to release, upon the request of the Division of Occupational and Professional Licenses or its authorized representative, any information, communication, report, record, statement, disclosure, or recommendation that may have bearing on my eligibility for or maintenance of the license for which I am applying. I also hereby authorize the Division of Occupational and Professional Licenses to release to any other regulatory entity in any jurisdiction any information requested about me that may otherwise be otherwise protected or confidential that may have bearing on my eligibility for, or maintenance of any license issued after this application. I (and, if I am under 18 my undersigned parent or guardian) request that the Athletic Commission grant me a license.

____ ____

Signature of Applicant Signature of Parent or Guardian if Under 18 Years of Age

State of ______________, County of _________________, ss.

Subscribed and sworn before me this _______ day of _______________________, 20 _____.

(seal) ____

Notary Public Official Signature
My Commission Expires____

FEMALE COMBATANT AFFIDAVIT

I, ____ , do hereby affirm that I have taken a reliable means of pregnancy testing as required by IDAPA 03.02.01-017.04 and that I will not participate in the contest if I am pregnant or during a menstrual period.

____

Signature of Applicant

Note: The applicant's signature must be notarized. The applicants must declare the answers provided are true in front of a notary (jurat). The language "subscribed and sworn" must appear before the applicant's signature. An "acknowledgement" where the notary only verifies the identity of the applicant is not acceptable.

Idaho Athletic Commission
Commissioner Lewis Stoddard

PHYSICIAN'S LICENSING EXAM: BOXING/MIXED MARTIAL ARTS

Legal Name:____
Last First Middle

Address:____
Street City State Country

Date of Birth:_____ / _____ / _______ Sex: ☐ M ☐ F Federal/National ID#:__________________

PHYSICAL EXAM: This section is to be completed by the examining physician.

Height:________ Weight:________ Temp:_______ ☐ Afebrile RR:_______ BP:_______/_______ HR:________

		Normal	Abnormal
General		☐	☐
HEENT	Head	☐	☐
	ERRLA/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:_______________			

Abnormals:____

MEDICAL TESTING:	**Negative/Normal**	**Positive**	**Not Reviewed**	**Not Required**	**Date of test/exam**
Hepatitis B Surface Antigen	☐	☐	☐	☐	____ /_____/ _____
Hepatitis C Antibody	☐	☐	☐	☐	____ /_____/ _______
HIV Antibody or Quantitative RNA	☐	☐	☐	☐	____ /_____/ _______
CT Scan/MRI Brain (circle)	☐	☐	☐	☐	____ /_____/ _______
EKG	☐	☐	☐	☐	____ /_____/ _______
Ophthalmologic Examination (Uncorrected vision must be at least 20/60)	☐	☐	☐	☐	____ /_____/ _______
Neurological Examination	☐	☐	☐	☐	____ /_____/ _______
Women: HCG Urine/Serum	☐	☐	☐	☐	____ /_____/ _______
Other:_________________	☐	☐	☐	☐	____ /_____/ _______

I hereby certify that based on the statements made by the participant on this form, my physical findings, and pending any medical testing not yet reviewed, it is my opinion that said participant ☐ **IS** ☐ **IS NOT** in good physical condition and is medically cleared to be licensed as a competitor in professional boxing/mixed martial arts.

☐ **The athlete presented a valid form of photo identification and I have personally verified his/her identity.**

Reason not cleared for competition:____

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

Office Address ____________ Phone ____________ Fax ____________

Rev. 12/12/12

IDAHO ATHLETIC COMMISSION
CONTESTANT LICENSE APPLICATION

HIPAA AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, ___________________________ authorize the Idaho Athletic Commission to release any of my medical information to the following:

- ☐ Any Physician in Idaho (List any exceptions) ___________________________________
- ☐ Any Emergency Medical Technician in Idaho (List any exceptions)___________________
- ☐ Any Hospital in Idaho (List any exceptions)_____________________________________
- ☐ The Promoter (Promoter's name)____
- ☐ A Relative (List name and Relation)____
- ☐ Any Athletic Commission that is a member of the Association of Boxing Commissions (ABC) (List any exceptions) ____

The following people, not otherwise listed ______________________________________

I understand that this "HIPAA Authorization to Release Medical Information" will remain in effect 365 days from the date below. I also understand that I reserve the right to revoke the contents herein at any time during the period this form is valid and complete a new form.

Printed Name:_________________ Signature:_______________________ Date:____________

Commission Rep:________________________ Date:_______________________________