Idaho Athletic Commission

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	☐	☐
	PERRLA/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 (circle)	☐	☐	☐	☐	_______/_______/_______
CT Scan/MRI Brain (circle)	☐	☐	☐	☐	_______/_______/_______
EKG	☐	☐	☐	☐	_______/_______/_______
Ophthalmologic Examination (Uncorrected vision must be at least 20/60)	☐	☐	☐	☐	_______/_______/_______
Neurological Examination	☐	☐	☐	☐	_______/_______/_______
Women: HCG Urine/Serum (circle)	☐	☐	☐	☐	_______/_______/_______
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