WASHINGTON STATE DEPARTMENT OF LICENSING

Physical Examination for Referees and Professional Combative Sports Participants

[redacted]

This packet must be completed and signed by a licensed M.D., D.O., or N.D. ONLY.

Give this packet to your examining licensed medical doctor to complete.

Send only page 1 to us by mail or email to:

Combative Sports Program
Department of Licensing
PO Box 9026
Olympia, WA 98507-9026

Email: dolcombativesports@dol.wa.gov

For questions or language help call: (360) 664-6644.

Memo to licensed medical doctor

To certify that an applicant is physically fit to safely compete or participate in a boxing, martial arts, or wrestling contest they must:

- be in excellent health at the time of this physical.
- have all required blood and urinalysis test results completed.
- meet the vision requirements on page 3 of this form.
- meet or exceed the minimum standard limits listed on page 4 of this form.
- not have any disease or condition that would be detrimental to their own health and safety or the health and safety of other participants or the general public.
- have negative results for HIV/HEP B Surface Antigen/HEP C (boxing, martial arts, and wrestling participants only).
- have an EKG and MRI of the brain if 37 years of age or older or have had 6 or more loses in a row

Applicant information

PRINT or TYPE Name				Federal ID number (Boxers only)
Address				
City			State	ZIP code
(Area code) Phone number	Date of birth	Height	Weight	Ring name
Military? *(check if applicable)* Current or former: ☐ Military member ☐ Military spouse or domestic partner				

Examining licensed medical doctor information (M.D., D.O., or N.D. ONLY)

PRINT or TYPE Name		(Area code) Phone number
Address		
City	State	ZIP code
Medical license number	Jurisdiction	

Answer the following

1. Has the physical examination been completed? . . . . . ☐ Yes ☐ No
2. Has the visual examination been completed? . . . . . ☐ Yes ☐ No
3. Has the required lab and blood tests been completed? . . . . . ☐ Yes ☐ No
4. Do you find the applicant to be physically fit to safely compete or participate in a boxing, martial arts, or wrestling contest? . . . . . ☐ Yes ☐ No

I declare under penalty of perjury under the law of Washington that the foregoing is true and correct.

TYPE or PRINT Name of examining licensed medical doctor

X **Examining licensed medical doctor signs here.**

Examining licensed medical doctor signature **(M.D., D.O., or N.D. ONLY)**

Date and place

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When all pages of the form are completed, send only page 1 to us. Keep the remainder for your records.

Applicant information

PRINT or TYPE Name	Ring name	
Home address		
City	State	ZIP code
(Area code) Phone number	Date of birth	

History–past and present

Answer all questions below

1. Bleeding disorder . . . . . ☐ Yes ☐ No
2. Seizures or convulsions . . . . . ☐ Yes ☐ No
3. Rheumatic fever . . . . . ☐ Yes ☐ No
4. Asthma or shortness of breath . . . ☐ Yes ☐ No
5. High blood pressure . . . . . ☐ Yes ☐ No
6. Heart disease . . . . . ☐ Yes ☐ No
7. Tuberculosis . . . . . ☐ Yes ☐ No
8. Sickle Cell Disease . . . . . ☐ Yes ☐ No
9. A kidney, lung, testicle, or eye removed . . . . . ☐ Yes ☐ No
10. Kidney disease . . . . . ☐ Yes ☐ No
11. Concussion or unconsciousness . ☐ Yes ☐ No
12. Mononucleosis . . . . . ☐ Yes ☐ No
13. Medical allergies . . . . . ☐ Yes ☐ No
14. Blurring of vision . . . . . ☐ Yes ☐ No
15. Wear/worn glasses or contact lenses . . . . . ☐ Yes ☐ No
16. Hepatitis . . . . . ☐ Yes ☐ No
17. Diabetes . . . . . ☐ Yes ☐ No
18. Physical impairment . . . . . ☐ Yes ☐ No
19. Skin disease . . . . . ☐ Yes ☐ No
20. Chronic cough . . . . . ☐ Yes ☐ No
21. Frequent headaches . . . . . ☐ Yes ☐ No
22. Swollen joint, joint injury or dislocation . . . . . ☐ Yes ☐ No
23. Spitting of blood . . . . . ☐ Yes ☐ No
24. Surgery or hospitalization . . . . . ☐ Yes ☐ No
25. Substance abuse . . . . . ☐ Yes ☐ No
26. Communicable diseases . . . . . ☐ Yes ☐ No
27. Recent fractures . . . . . ☐ Yes ☐ No
28. Rupture (hernia) . . . . . ☐ Yes ☐ No
29. Dizzy or fainting spells . . . . . ☐ Yes ☐ No
30. Rheumatism/Arthritis . . . . . ☐ Yes ☐ No

No one should present himself/herself for a physical or apply for a license who has any physical impairment which limits his/her ability, or any dangerous communicable diseases or any disease of the vital organs, whether acute or chronic.

Do you have any other information concerning your health, past or present, which is not covered by the above questions? . . . . . ☐ Yes ☐ No
If "Yes," describe fully:

Are you taking any medication or drugs? . . . . . ☐ Yes ☐ No
If "Yes," name, address, phone number of prescribing physician, name of medication:

How many knockouts have you suffered? _____ Date of last KO _____

Longest duration of unconsciousness _____

Length of time before resuming boxing after last KO _____

Have you ever been knocked unconscious in any other sport or activity? . . . . . ☐ Yes ☐ No

Do you have 6 or more loses in a row? . . . . . ☐ Yes ☐ No

(continued on next page)

Applicant name _____

Vision Requirements

The Department of Licensing shall deny, suspend or revoke a license if it determines that the applicant or licensee cannot safely engage in activities because of a visual condition, including but not limited to one of the following:

1. Uncorrected visual acuity of less than 20/100 in either eye.
2. Corrected visual acuity of less than 20/60 in either eye (amblyopia), regardless of its cause.
3. A cataract in either eye which reduces vision to 20/40 or less.
4. Presence or history of retinal detachment or retinal tear (excluding choroidal tear), whether or not such condition has been treated.
5. Presence of primary glaucoma, whether or not such condition has been treated.
6. Presence of aphakia, pseudophskia or dislocated lens in either eye.

Applicants with the following conditions may be licensed if he/she presents satisfactory written evidence from an ophthalmologist stating that the person can safely engage in activities. The written evidence shall specifically address the problem, the effect if any, that participation may have on the problem, and the frequency of subsequent examinations.

a. Cataract in either eye and corrected vision is better than 20/40 or less.
b. Ocular pathology of any kind which is self-limiting or treatable and which generally results in a return to normal ocular function.
c. Any other visual condition which the Department determines would prevent the applicant or licensee from safely engaging in activities.

Eye exam

	Right	Left
Distant vision	20/	20/
Near vision	20/	20/
Pupils (size & shape)	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal
Accommodation & light reflex	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal
Fundi (describe if abnormal)	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal
Cataracts (describe)	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal
Lids	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal
Glaucoma	☐ No ☐ Yes	☐ No ☐ Yes

(continued on next page)

Applicant name _____

Minimum standards (All areas listed on physical exam must be within normal limits)

1. Blood pressure no higher than 160/90.
2. Temperature below 100.
3. No abnormal conditions that would limit participation ability.
4. No hernias containing abdominal contents on coughing or straining.
5. Normal reflexes.
6. No suppurative lesions on skin.
7. No indication of active renal disease.
8. Negative controlled substance and blood tests.
9. No history of cerebral hemorrhage or any other serious head injury.
10. No communicable diseases present or other conditions that can be transmitted by blood or detrimental to applicant or others.

Height _____ **Weight** _____ **Temperature** _____ **Pulse** _____

Blood pressure _____

Ears: ☐ Normal ☐ Abnormal **Perforated drums:** ☐ Yes ☐ No

Mouth and pharynx: ☐ Normal ☐ Abnormal

Teeth: ☐ Normal ☐ Abnormal

Lungs: ☐ Normal ☐ Abnormal

Heart: Pulse rhythm ☐ Regular ☐ Irregular
Apical pulse ☐ Heaving ☐ Normal
Enlargement ☐ Yes ☐ No **Murmurs:** ☐ Yes ☐ No

Abdomen: Enlargement of liver ☐ Yes ☐ No
Enlargement of spleen ☐ Yes ☐ No
Hernia ☐ Femoral ☐ Inguinal ☐ Ventral ☐ No

Enlarged glands: ☐ Yes ☐ No **Goiter:** ☐ Yes ☐ No

Genitalia: ☐ Normal ☐ Abnormal
Discharge ☐ Yes ☐ No
Varicocele ☐ Yes ☐ No

Reflexes:	Normal	Abnormal
Knee jerk	☐ Rt ☐ Lft	☐ Rt ☐ Lft
Babinski	☐ Rt ☐ Lft	☐ Rt ☐ Lft
Romberg	☐	☐
Finger to nose	☐	☐
Pupils	☐ Rt ☐ Lft	☐ Rt ☐ Lft

Upper extremities: (check for recent injury, fracture or swellings)

	Normal	Abnormal
Hands	☐	☐
Wrists	☐	☐
Elbows	☐	☐
Shoulder girdle	☐	☐
Lower extremities	☐	☐

(continued on next page)

Applicant name _____

Skin: Open or suppurative lesions: ☐ Yes ☐ No
Rash: . . . . . ☐ Yes ☐ No Boils: . . . . . ☐ Yes ☐ No

Urinalysis: Total protein _____ Sugar _____

Blood:
Test for the following communicable diseases transmitted by blood; HIV/HEP B Surface Antigen/HEP C (see Memo to Physician on page 1 of this form).

☐ Positive ☐ Negative

Controlled substance: (If indicated or requested)

Results _____

Chest x-ray: (If indicated or requested)

Results _____

EKG: (If indicated or requested)

Results _____

EEG: (If indicated or requested)

Results _____

CT: (If indicated or requested)

Results _____

MRI: (If indicated or requested)

Results _____

Physician's remarks: