



OREGON STATE POLICE

Oregon State Athletic Commission

4190 Aumsville Hwy SE

Salem OR 97317

TELEPHONE: 503-378-8739 FAX: 503-378-2530

REPORT OF PHYSICAL EXAMINATION



Name:	Ring Name:		
Home Address:	City:	State:	Zip:
Date of Birth:	Age:		

HISTORY: Has the applicant ever had any of the following?

- | | | |
|--------------------------|-------------------------|---------------------------|
| _____ Swollen Joints | _____ Rheumatism | _____ Shortness of breath |
| _____ Chronic Cough | _____ Spitting of Blood | _____ Blurring of Vision |
| _____ Convulsions (Fits) | _____ Fainting Spells | _____ Operations |
| _____ Rupture (Hernia) | _____ Wear/Worn Glasses | _____ Diabetes |
| _____ Dizzy Spells | _____ Bleeding Disorder | |

How many knockouts has fighter suffered:	Date of last knockout:	Length of time before fighting after last knockout:
Longest duration of unconsciousness:		
Ever knocked unconscious in other sports or in any other way: <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, explain fully:		

EXAMINATION

General Appearance:	Height:	Weight:	Temperature:
Disabling Scars:	Mouth:	Teeth:	Tonsils
			Neck
Pulse:	Blood pressure at rest:	Pulse after 100 Hops	Blood pressure after 100 hops
Pulse 2 minutes later		Blood pressure 2 minutes later	

EYES

Vision without glasses:	Right:	Left:	Pupils equal: Yes <input type="checkbox"/> No <input type="checkbox"/>	Goiter: Yes <input type="checkbox"/> No <input type="checkbox"/>
Comments:				

EARS

Ears:	Nose:
Comments:	

HEART

Pulse Rhythm:	Regular:	Irregular:	Apical Pulse:	Heaving:	Normal
Comments:					

LUNGS

Rales:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Comments:		

ABDOMEN

Enlargement of liver:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Enlargement of spleen:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Comments:					

Name:

Date of Birth:

GENITALIA

Discharge: Yes No

Varicocele: Yes No

Comments:

HANDS

Evidence or recent injury, fracture, swelling:

Unhealed Wounds:

REFLEXES

Pupils: Light & Acuteness: R ___ L ___ Knee Jerks: R ___ L ___ Romberg: R ___ L ___ Babinski: R ___ L ___ Ankle Jerks: R ___ L ___

Comments:

OTHERS

Skin: Rash _____

Boils _____

Any other:

Urinalysis: (Dipstick)

Comments:

Serology:

HIV/AIDS – The original or certified lab report of a negative result must be submitted.

Hepatitis B Surface Antigen – The original or certified lab report of a negative result must be submitted.

Hepatitis C Antibody – The original or certified lab report of a negative result must be submitted.

Drug Screen (when required by Commission):

Abusive Drugs – The original or certified lab report of a negative result must be submitted.

- Methadone
- Morphine
- Meperidine
- Propoxyphene
- Quinine
- Barbiturates
- Clutethimide
- Chlorpromazine
- Codeine
- Cocaine
- D-Amphetamine
- Marijuana
- Any central nervous system stimulant or depressant whether obtained by prescriptions or otherwise
- Heroin
- Metabolic steroids

The current HIV, Hepatitis and Drug Abuse policy is as follows:

Every fighter applying for a license in Oregon must present original or certified laboratory test results reflecting that the applicant is negative for the presence of HIV virus and Hepatitis B and C.

Examining Physician's Comments:

I (examining physician) have examined the above named subject and find him/her, in my opinion, to be in (_____ **Satisfactory** _____ **Unsatisfactory**) condition to be licensed as a boxer/MMA Fighter/Referee.

Date of Exam

Physician's Name (**Please Print**)

Physicians' Signature

Address

Date

City, State, Zip

Phone Number

I hereby declare under penalty of perjury, that the forgoing history is true and correct: further, I realize that any misrepresentation in said medical history may result in disciplinary action.

Signature of Applicant

Date Signed