STATE OF WASHINGTON

DEPARTMENT OF LICENSING

To: Examining Physician

From: Department of Licensing
Professional Athletics
PO Box 9026
Olympia, WA 98507-9026
(360) 664-6644 or Fax (360) 570-4956

Cover letter and certification of physical for boxers,boxing referees, martial arts participants, and wrestling participants.

Return this completed page to the Department of Licensing at the address above.

Applicant name (Please print)			Federal I.D. number (Boxers only)		
Address			City	State	ZIP code
Birthday		Social Security number (Required per RCW 26.23.150)		Area code and telephone number	
Height	Weight	Ring name			

The physical and visual examination and required lab and blood tests have been completed on the applicant and I find his/her medical conditon to be: ☐ Satisfactory ☐ Unsatisfactory

My recommendation for license is: ☐ Grant license ☐ Deny license

Examining physician's name (please print)	Area code and telephone number	
Address		
City	State	ZIP

I certify under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

Date and Place	Signature X

The Department of Licensing has a policy of providing equal access to its services.
If you need special accommodation, please call (360) 664-6644 or TTY (360) 664-8885.

Memo to Physician

Applicants should be in excellent health at the time of this physical in order to be recommended for licensure.

All required blood and urinalysis test results must be completed before recommending a person for a license.

If any applicant exceeds the minimum standard limits listed on page 5 of this form, or has 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, then you, as the examining physician, should indicate that you find this applicant in an unsatisfactory medical condition and recommend that this applicant's license be denied.

Blood tests are mandatory for communicable diseases or conditions; HIV/HEP B/HEP C. If any test is positive, mark unsatisfactory medical condition and recommend to deny license. Please return only page one to the Department of Licensing.

If you have any questions, please feel free to contact the Department of Licensing, Professional Athletics Section at (360) 664-6644.

WASHINGTON STATE DEPARTMENT OF LICENSING

Physical Examination Report for Boxers, Boxing Referees, Martial Arts Participants, and Wrestling Participants

PROFESSIONAL ATHLETICS
P.O. BOX 9026
OLYMPIA, WA 98507-9026
PHONE (360) 664-6644
FAX: (360) 570-4956
E-MAIL: plssunit@dol.wa.gov
dol.wa.gov

Applicant name (Please print)	Ring name	
Home address		
City	State	ZIP code
Area code and telephone number	Birthdate	

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

When all pages of the form are completed, forward page one only.

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

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 electroencephalographic change.
10. No history of cerebral hemorrhage or any other serious head injury.
11. 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

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: . . . . . . Normal Abnormal
Hands . . . . . . ☐ ☐ (Check for recent injury, fracture or swellings.)
Wrists . . . . . . ☐ ☐
Elbows . . . . . . ☐ ☐
Shoulder girdle . . . . . . ☐ ☐
Lower extremities . . . . . . ☐ ☐

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 trasmitted by blood; HIV/HEP B/HEP C
(see Memo to Physician on page 2 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: ____

I have examined the applicant and find him/her in a ☐ Satisfactory ☐ Unsatisfactory medical condition.
My recommendation for license is: ☐ Grant license ☐ Deny license

Examining physician's name (please print)	(Area code) Telephone number	
Address		
City	State	ZIP code

I certify under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

Date and Place	Signature
	X