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

This packet must be completed and signed by an M.D. or D.O.

Give this forms packet to your examining physician to complete. Send page one only to us by mail, fax, or scan and email to:

Professional Athletics
Department of Licensing
PO Box 9026
Olympia, WA 98507-9026

Fax: (360) 570-4956
Email: plssunit@dol.wa.gov
If you need assistance, please call (360) 664-6644.

Memo to physicians

To certify that an applicant is physically fit to safely compete or participate in a boxing, martial arts, or wrestling contest applicants 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/HEP C (boxing, martial arts, and wrestling participants only)

Applicant information

PRINT or TYPE Name			Federal I.D. number (Boxers only)	
Address				
City			State	ZIP code
Date of birth		Social Security number – required for child support enforcement. Kept on file at DOL.		(Area code) Telephone number
Height	Weight	Ring name		

Examining physician information

PRINT or TYPE Name		(Area code) Telephone number
Address		
City	State	ZIP code

Answer the following

Has the physical and visual examination been completed? . . . . ☐ Yes ☐ No

Has the required lab and blood tests been completed? . . . . ☐ Yes ☐ No

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

Date and place ____________________

X ____________________
Examining physician signature (M.D. or D.O.)

We are committed to providing equal access to our services.
If you need accommodation, please call (360) 664-6644 or TTY (360) 664-0116.

WASHINGTON STATE DEPARTMENT OF LICENSING

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

This packet must be completed and signed by an M.D. or D.O. When all pages of the form are completed, send page one only to us.

Applicant information

PRINT or TYPE Name		Ring name
Home address		
City	State	ZIP code
(Area code) 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

(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 trasmitted by blood; HIV/HEP B/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:

Examining physician information

PRINT or TYPE Name		(Area code) Telephone number
Address		
City	State	ZIP code

Answer the following

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

____________________   **X** ____________________

Date and place   Examining physician signature (M.D. or D.O.)

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