



TEXAS DEPARTMENT OF LICENSING & REGULATION

P.O. Box 12157 • Austin, Texas 78711-2157

www.tdlr.texas.gov

COMBATIVE SPORTS PROFESSIONAL CONTESTANT LICENSE APPLICATION INSTRUCTIONS

1. NAME – Provide your legal name in the spaces provided. (Last, First, Middle Name, Suffix) Examples of a suffix include Jr., Sr., and (Mr. is not a suffix.)
2. DATE OF BIRTH – Provide your birth date. Minors age 17 but not yet 18 may be issued a contestant's license with a notarized written consent from a parent or guardian.
3. PLACE OF BIRTH – Provide the city, state, and country of your place of birth.
4. GENDER - Select whether you are male or female.
5. SOCIAL SECURITY NUMBER – Social security number disclosure is required by Section 231.302(c)(1) of the Texas Family Code in order to obtain a license. Your social security number is subject to disclosure to an agency authorized to assist in the collection of child support payments, contact the [Texas Attorney General](#).
6. FOREIGN NATIONAL PASSPORT NUMBER – Applicants who are foreign nationals, must provide their passport number.
7. MAILING ADDRESS – Provide your current mailing address. This is the address where we will send you mail. This address can be a post office box. Add the zip plus-4 to help the postal service deliver mail more efficiently and accurately.
8. EMAIL ADDRESS – Provide your email address. By providing my email address I authorize TDLR to send licensing communications and required notices to me by electronic mail. I understand that I may revoke this authorization in writing and that I must update my email address, or I will not receive these notices. I understand that the email address I have provided in this application will remain confidential except as permitted or required by law.
9. PHONE NUMBER – Provide a telephone number, including the area code, where we can reach you during the day. This may be your office phone number where we can leave a message.
10. EVENT DATE – Provide the date of the combative sports event you are participating in.
11. PROMOTER NAME – Provide the name of the promoter of the combative sports event.
12. STATEMENT OF APPLICANT – Carefully read the statement before you sign and date your application.

APPLICATION INFORMATION FOR MILITARY SERVICE MEMBERS, MILITARY VETERANS, AND MILITARY SPOUSES:

The Texas Department of Licensing and Regulation recognizes the contributions of our active duty military service members, their spouses, and veterans. If you want to use one of the licensing options available to military service members, military veterans and military spouses, please complete the [Military Service Member, Military Veteran or Military Spouse Supplemental Application \(PDF\)](#) and attach it with your license application. If you have additional questions about qualifications, training or experience requirements relating to occupation licensing for military service members, military veterans or military spouses please go to [TDLR Military Information](#).

SEND YOUR COMPLETED APPLICATION AND REQUIRED DOCUMENTS TO:

Texas Department of Licensing and Regulation
P.O. Box 12157
Austin, TX 78711-2157

Documents submitted with your application will not be returned. Keep a copy of your completed application, all attachments, and your check or money order. Do not send cash.

For additional information and questions, visit the [TDLR website](#) or reach Customer Service via [webform](#). The webform will allow you to submit your request for assistance and include attachments needed. Customer Service Representatives are available Monday through Friday (excluding holidays) at (800) 803-9202 (in state only), (512) 463-6599, or Relay Texas-TDD: (800)735-2989.

TDLR PUBLIC INFORMATION ACT POLICY:

This document is subject to the Texas Public Information Act. With certain exceptions, information in this document may be made available to the public. For more information, view the [TDLR Public Information Act Policy](#).



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COMBATIVE SPORTS PROFESSIONAL CONTESTANT LICENSE APPLICATION

YOU MUST MEET ALL REQUIREMENTS WITHIN 12 MONTHS OF THE FILING DATE, OR THE APPLICATION WILL BE TERMINATED.

APPLICATION FEE: \$20 (FEE IS NON-REFUNDABLE)

1. Name:

Last First Middle Name Suffix (SR, JR, III)

2. Date of Birth:

mm/dd/yyyy

3. Place of Birth: (City, State, and Country)

4. Gender:

☐ Male ☐ Female

5. Social Security Number:

(See instruction sheet for disclosure information)

6. Foreign National Passport Number: (Foreign nationals must provide their passport number)

7. Mailing Address: (A PO box is allowed for this address)

Number, Street Name, Suite Number/Apartment Number

City

State

Zip Code

8. Email Address:

(Ex: johndoe@gmail.com) See instruction sheet for disclosure information

9. Phone Number:

Phone Number

10. Event Date:

mm/dd/yyyy

11. Promoter Name:

12. STATEMENT OF APPLICANT

I certify that I have read and will comply with all applicable laws and rules of the Combative Sports Program including Texas Occupations Code, Chapter 51 and Chapter 2052 (Combative Sports Act) and the Combative Sports Administrative Rules under 16 Texas Administrative Code, Chapter 60 and Chapter 61.

I understand that providing false information on this application may result in denial of this application and/or revocation of the license I am requesting and the imposition of administrative penalties.

Applicant Signature

Date Signed



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PROFESSIONAL CONTESTANT'S MEDICAL EXAMINATION INSTRUCTIONS

1. **PROFESSIONAL CONTESTANT'S MEDICAL EXAMINATION** Parts 1 must be completed by the contestant. Part 2 must be completed by a medical doctor licensed by a state, district, or territory of the United States of America. Part 2 signed by a physician's assistant or nurse practitioner will not be accepted. A contestant's medical examination records are only valid for six months from the date of completion.
2. **OPHTHALMOLOGIC MEDICAL EXAMINATION** This exam must be completed by an ophthalmologist or optometrist licensed by a state, district, or territory of the United States of America. Ophthalmologic medical examination records are only valid for six months from the date of completion.

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Please read this entire form before signing and complete all sections.

1. I authorize the Texas Department of Licensing and Regulation to use and disclose my protected health information/medical records to other governmental entities or myself with respect to my status as a licensed contestant.
2. This authorization for release of information covers all past, present, and future medical records.
3. I authorize the release of all protected health information/medical records submitted to TDLR as a part of the following:
 - Professional Contestant's Medical Examination - Part 1
 - Professional Contestant's Medical Examination - Part 2
 - Ophthalmologic Medical Exam
4. I understand that the authorization to release **all** of the above-referenced protected health information/records **includes** the release of information/records relating to communicable diseases, *Human Immunodeficiency Virus (HIV)* or Acquired Immune Deficiency Syndrome (**AIDS**).
5. This authorization shall remain in effect until the expiration of my license, at which time this authorization expires.
6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I have read this form and agree to the uses and disclosure of the health information/medical records as described.

I understand that refusing to sign this form does not affect disclosures of health information/medical records that have occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission.

I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy law.

I also understand that this information may be subject to release under the Texas Public Information Act or other law.

PRINT NAME OF APPLICANT

SIGNATURE OF APPLICANT

DATE SIGNED



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PROFESSIONAL CONTESTANT'S MEDICAL EXAMINATION - PART 1

Last Name _____ Federal/National ID: _____
Last First Middle
Address: _____
Street Number, Street Name City State County
Telephone: _____ Email: _____ Date of Birth: _____
Sex: ☐ M ☐ F Emergency Contact: _____ Emergency Telephone: _____

ALL SECTIONS MUST BE ANSWERED

Health History - Do you have or have you ever had any of the following?

	Yes	No		Yes	No
Seizure, flashing lights	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Headaches or dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Asthma or wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral hemorrhage	<input type="checkbox"/>	<input type="checkbox"/>	Broken bones or recent sprains	<input type="checkbox"/>	<input type="checkbox"/>
Passed out during exercise	<input type="checkbox"/>	<input type="checkbox"/>	Neck or spine injury	<input type="checkbox"/>	<input type="checkbox"/>
Double or blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>
LASIK, PRK, or other eye surgery	<input type="checkbox"/>	<input type="checkbox"/>	Cold sores, fever blisters or	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	Herpes Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hearing difficulty	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>
Broken nose	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis or liver problems	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Heat stroke/heat exhaustion	<input type="checkbox"/>	<input type="checkbox"/>
Irregular heart beat or murmur	<input type="checkbox"/>	<input type="checkbox"/>	Recent illness or fever	<input type="checkbox"/>	<input type="checkbox"/>
Muscle cramping during exercise	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell trait or disease	<input type="checkbox"/>	<input type="checkbox"/>

Results of the following blood tests MUST be attached to the application:

☐ Hepatitis B Surface ANTIGEN ☐ Hepatitis C ANTIBODY ☐ HIV ANTIBODY

	Yes	No
Have you ever had a concussion, a head injury, or lost consciousness?	<input type="checkbox"/>	<input type="checkbox"/>
Do you or have you ever used steroids, testosterone, or banned substances?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any other surgeries?	<input type="checkbox"/>	<input type="checkbox"/>
Have you seen a doctor for <i>any</i> medical problem in the last 3 months?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any other medical conditions or training/sparring injuries?	<input type="checkbox"/>	<input type="checkbox"/>
<i>Women only:</i> Have you ever had any type of breast surgery?	<input type="checkbox"/>	<input type="checkbox"/>
What medications or supplements are you taking on a regular basis?	_____	
What medications or supplements have you taken within the last two weeks?	_____	
If "Yes" to any of the above, explain:	_____	

A PERSON 36 YEARS OF AGE OR OLDER MUST SUBMIT A FAVORABLE

☐ EEG (Electroencephalography) AND ☐ EKG (electrocardiogram)

I understand that the examining physician depends on the reliability of the statements I made above I attest that the answers given above are true and correct to the best of my knowledge and belief.

Contestant Applicant Name (printed)

Signature

Date



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PROFESSIONAL CONTESTANT'S MEDICAL EXAMINATION - PART 2

This form **MUST** be completed by a LICENSED PHYSICIAN (M.D./D.O.)

Last Name: _____ Federal/National ID: _____
Last First Middle

Address: _____
Street Number and City State County
Name

Telephone: _____ E-mail: _____ Date of Birth: _____

Sex: ☐ M ☐ F Emergency Contact: _____ Emergency Telephone: _____

ALL SECTIONS MUST BE ANSWERED

PHYSICAL EXAM: This section is to be completed by the examining physician.

☐ The athlete presented a valid form of photo identification and I have personally verified his/her identity.

Height: _____ Weight: _____ Temp: _____ RR: _____ BP: _____/_____ HR: _____

	Normal	Abnormal		Normal	Abnormal
General			Abd.		
HEENT Head	<input type="checkbox"/>	<input type="checkbox"/>	(Hernias)	<input type="checkbox"/>	<input type="checkbox"/>
PERRLA/EOMI	<input type="checkbox"/>	<input type="checkbox"/>	(Masses/Tenderness)	<input type="checkbox"/>	<input type="checkbox"/>
Periorbital Regions	<input type="checkbox"/>	<input type="checkbox"/>	Ext. Extremities	<input type="checkbox"/>	<input type="checkbox"/>
Ears/Hearing (grossly)	<input type="checkbox"/>	<input type="checkbox"/>	Hands/Wrists	<input type="checkbox"/>	<input type="checkbox"/>
Jaw/Oropharynx/Teeth	<input type="checkbox"/>	<input type="checkbox"/>	Knuckle Push-ups	<input type="checkbox"/>	<input type="checkbox"/>
Nose (stability, obstruction)	<input type="checkbox"/>	<input type="checkbox"/>	Duck/Crab walk	<input type="checkbox"/>	<input type="checkbox"/>
Lymph Nodes	<input type="checkbox"/>	<input type="checkbox"/>	Skin (Rashes/Lacerations)	<input type="checkbox"/>	<input type="checkbox"/>
Neck	<input type="checkbox"/>	<input type="checkbox"/>	Neuro. Alertness/Orientation	<input type="checkbox"/>	<input type="checkbox"/>
Vision PERRLA/EOMI	<input type="checkbox"/>	<input type="checkbox"/>	Cranial Nerves (grossly)	<input type="checkbox"/>	<input type="checkbox"/>
Peripheral/Fields (grossly)	<input type="checkbox"/>	<input type="checkbox"/>	Tandem Gait	<input type="checkbox"/>	<input type="checkbox"/>
Heart Rhythm/Sounds/Murmurs	<input type="checkbox"/>	<input type="checkbox"/>	Romberg/Pronator Drift	<input type="checkbox"/>	<input type="checkbox"/>
Chest Lungs	<input type="checkbox"/>	<input type="checkbox"/>	Finger to Nose	<input type="checkbox"/>	<input type="checkbox"/>
Ribs	<input type="checkbox"/>	<input type="checkbox"/>	Reflexes	<input type="checkbox"/>	<input type="checkbox"/>
			Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

Abnormals: _____

I hereby certify that based on the statements made by the contestant applicant on the reverse side of this form, my physical findings, and pending any medical testing not yet reviewed, it is my opinion that contestant applicant ☐ IS ☐ IS NOT in good physical condition and ☐ IS ☐ IS NOT medically cleared to be licensed as a contestant in a professional boxing/mixed martial arts event.

Reason if NOT cleared for competition: _____

Physician's Name, M.D./D.O.

Signature

License No.

Date

Office Address

Phone

Fax



OPHTHALMOLOGIC MEDICAL EXAMINATION

This form must be completed by a LICENSED OPHTHALMOLOGIST or OPTOMETRIST

Legal Name: _____
Last First Middle

Date of Birth: _____
mm/dd/yyyy

ALL SECTIONS MUST BE ANSWERED

Visual Acuity Measurement

Without Correction

RIGHT EYE	LEFT EYE	Normal	Abnormal
N /	N /	<input type="checkbox"/>	<input type="checkbox"/>

F /	F /	<input type="checkbox"/>	<input type="checkbox"/>
-----	-----	--------------------------	--------------------------

With Correction

N /	N /	<input type="checkbox"/>	<input type="checkbox"/>
-----	-----	--------------------------	--------------------------

F /	F /	<input type="checkbox"/>	<input type="checkbox"/>
-----	-----	--------------------------	--------------------------

Tonometry Measurements

_____ mmHg	_____ mmHg	<input type="checkbox"/>	<input type="checkbox"/>
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Exterior Exam

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Anterior Exam

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Fundi

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Extraocular Muscles Visual

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Fields (confrontation)

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Explain Abnormal Findings: _____

Diagnosis: _____

Dilated exam was performed on _____ Date of exam: _____
Applicant Contestant Name mm/dd/yyyy

I APPROVED THIS PERSON TO PARTICIPATE IN A COMBATIVE SPORTS EVENT

Ophthalmologist or Optometrist Name (print): _____ License Number _____

Street Address: _____ City _____ State _____

Zip Code + 4

(Area Code) Phone Number

Ophthalmologist or Optometrist Signature: _____ Date _____

Contestant Applicant Name: _____ Printed Signature Date



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CONTESTANT CONSENT AUTHORIZING DRUG TESTING & RELEASE OF RESULTS

Your license will not be issued until all applicable forms are submitted and approved. If you have any questions regarding the application, please email: combative.sports@tdlr.texas.gov

I, _____, _____, _____, _____,
Last First Middle Suffix (Jr., Sr., III)

authorize the attending medical/laboratory (lab) technician to collect and analyze the urine specimen I am providing. I authorize the lab to release the test results to:

- Texas Department of Licensing and Regulation (Department); and
- the sanctioning body and/or promoter of the event in which I participate as a contestant.

I authorize the Department to release my drug test results 60 days after the Department receives my results.

I authorize the Department to update Box Rec or the MMA Registry based on the results of my drug test prior to the 60th day after receipt of my drug test results.

In the event my specimen indicates a positive result for any of the substances listed in Texas Administrative Code, Chapter 61.47 (q) 1-1, or exceeds the thresholds established by the testing lab designated by the Department's Executive Director, I understand that an automatic 90-day medical suspension is in effect, and I authorize the Department to use my test results in a disciplinary proceeding to suspend or revoke my license and assess an administrative penalty.

I understand that if I refuse to provide a urine specimen, do not comply with the testing process, or try to substitute, dilute, mask or adulterate a urine specimen, my actions will be considered the same as having a positive test result, my license may be suspended or revoked, and I may be ordered to pay an administrative penalty.

I understand that I can withdraw my consent for the release of my test results at any time by giving the Department written notice of my decision to withdraw my consent.

URINE SPECIMEN TESTING PROCEDURES AND YOUR RIGHTS:

- At the collection site: The specimen will be divided into two bottles labeled as a primary "A" specimen and a secondary "B" specimen and transported to the testing lab.
- At the lab: Only the "A" specimen will be opened and used for the urinalysis. The "B" specimen will remain sealed.
- **Positive result:** You will be notified by the Department if analysis of the "A" specimen indicates a positive result, or exceeds the threshold established by the testing lab designated by the Department's Executive Director.
- **Right to re-test:** In the event the "A" specimen tests positive for a prohibited substance or exceeds the established threshold, **you have five calendar days after receiving notification of a violation to request that the "B" specimen be analyzed at another Department-approved lab.** If you do not make a request within five calendar days, you waive your right to have the "B" specimen analyzed and you will accept the 90-day suspension under Texas Administrative Code, Chapter 61.47 (q).

Contestant Signature

Date



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PARENT/GUARDIAN CONSENT FORM

YOUR LICENSE WILL NOT COMPLETED UNTIL ALL APPLICABLE FORMS ARE SUBMITTED AND APPROVED.

If you have any questions regarding the application, please email: combative.sports@tdlr.texas.gov

I _____ PARENT or LEGAL GUARDIAN OF
_____, BORN ON THE _____ DAY OF
_____, 20_____ DO HEREBY GIVE MY CONSENT AND
AUTHORIZATION TO PARTICIPATE AS A COMBATIVE SPORT CONTESTANT.

I UNDERSTAND THE NATURE OF THE COMBATIVE SPORTS EVENT AND DUE TO MY
CHILD LEGALLY BEING OF A MINOR AGE, MY SIGNATURE SERVES AS A RELEASE
TO PERMIT MY CHILD TO PARTICIPATE AS A COMBATIVE SPORT CONTESTANT.

Parent/Guardian Signature

Date

Phone Number

Sworn and subscribed to before me this _____ day of _____ 20_____.

Notary Signature
Notary Public, State of Texas

My Commission expires:
