TEXAS DEPARTMENT OF LICENSING & REGULATION
P.O. Box 12157 • Austin, Texas 78711-2157
www.tdlr.texas.gov

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.

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.

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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

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

Address: _____ (Street Number, Street Name) _____ (City) _____ (State) _____ (Zip Code)

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	☐	☐	High blood pressure	☐	☐
Headaches or dizziness	☐	☐	Asthma or wheezing	☐	☐
Cerebral hemorrhage	☐	☐	Broken bones or recent sprains	☐	☐
Passed out during exercise	☐	☐	Neck or spine injury	☐	☐
Double or blurred vision	☐	☐	Hernia	☐	☐
LASIK, PRK, or other eye surgery	☐	☐	Cold sores, fever blisters or Herpes	☐	☐
Retinal Detachment	☐	☐	Diabetes	☐	☐
Hearing difficulty	☐	☐	Bleeding problems	☐	☐
Broken nose	☐	☐	Hepatitis or liver problems	☐	☐
Chest pain	☐	☐	Heat stroke/heat exhaustion	☐	☐
Irregular heart beat or murmur	☐	☐	Recent illness or fever	☐	☐
Muscle cramping during exercise	☐	☐	Sickle cell trait or disease	☐	☐

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?	☐	☐
Do you or have you ever used steroids, testosterone, or banned substances?	☐	☐
Have you ever had any other surgeries?	☐	☐
Have you seen a doctor for *any* medical problem in the last 3 months?	☐	☐
Do you have any other medical conditions or training/sparring injuries?	☐	☐
Women only: Have you ever had any type of breast surgery?	☐	☐

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.)

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

Address: _____ (Street Number and Name) _____ (City) _____ (State) _____ (Zip Code)

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
General			
HEENT	Head	☐	☐
	PERRLA/EOMI	☐	☐
	Periorbital Regions	☐	☐
	Ears/Hearing (grossly)	☐	☐
	Jaw/Oropharynx/Teeth	☐	☐
	Nose (stability, obstruction)	☐	☐
	Lymph Nodes	☐	☐
	Neck	☐	☐
Vision	PERRLA/EOMI	☐	☐
	Peripheral/Fields (grossly)	☐	☐
Heart	Rhythm/Sounds/Murmurs	☐	☐
Chest	Lungs	☐	☐
	Ribs	☐	☐

		Normal	Abnormal
Abd.	(Hernias)	☐	☐
	(Masses/Tenderness)	☐	☐
Ext.	Extremities	☐	☐
	Hands/Wrists	☐	☐
	Knuckle Push-ups	☐	☐
	Duck/Crab walk	☐	☐
Skin	(Rashes/Lacerations)	☐	☐
Neuro.	Alertness/Orientation	☐	☐
	Cranial Nerves (grossly)	☐	☐
	Tandem Gait	☐	☐
	Romberg/Pronator Drift	☐	☐
	Finger to Nose	☐	☐
	Reflexes	☐	☐
	Other: _____	☐	☐

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)

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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	**RIGHT EYE**	**LEFT EYE**	**Normal**	**Abnormal**
Without Correction	**N**____/____	**N**____/____	☐	☐
	F____/____	**F**____/____	☐	☐
With Correction	**N**____/____	**N**____/____	☐	☐
	F____/____	**F**____/____	☐	☐
Tonometry Measurements	_____ **mmHg**	_____ **mmHg**	☐	☐
Exterior Exam			☐	☐
Anterior Exam			☐	☐
Fundi			☐	☐
Extraocular Muscles Visual			☐	☐
Fields (confrontation)			☐	☐

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

_____ _____ _____
(Area Code) Phone Number Ophthalmologist or Optometrist Signature Date

_____ _____ _____
Contestant Name Printed Contestant Signature Date