Medical form must be filled out and signed by your doctor.

With a letter stating the following

Medical form must be accompanied by lab results showing negative results for Hepb surface antigen, HepC and HIV.

This must also be accompanied by a letter from your doctor stating that you are healthy enough to compete in combat sports.

*fighters 40 and over must supply EKG and results.

** all female fighters must submit to pregnancy test at event weight ins or must provide letter from doctor stating negative results no more than 48 hrs prior to Event

NEW YORK STATE OF OPPORTUNITY.

New York State Athletic Commission

New York State
Department of State
State Athletic Commission
123 William Street
New York, NY 10038-3804
Telephone: (212) 417-5700
www.dos.ny.gov/athletic

National Mixed Martial Arts Identification Application

Select Type (Check one only): ☐ **Professional** ☐ **Amateur**

To apply for an ASSOCIATION OF BOXING COMMISSIONS Mixed Martial Arts National Identification Card please complete the following:

FIRST NAME: _____ _____ _ LAST NAME: – MIDDLE:

DATE OF BIRTH: / / LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER:

ADDRESS: ___ CITY: _____ STATE: _____ ZIP: _____

HEIGHT: _____ WEIGHT: _____ HAIR COLOR: _____ EYE COLOR: _____

ALSO KNOWN AS: _____

PHONE (_____) _____ E-MAIL ADDRESS: _____

BIRTHMARKS, SCARS OR TATTOOS: _____

TERMS AND CONDITIONS:

1. Illegible applications will not be accepted. PLEASE PRINT LEGIBLY.
2. The first and last name supplied must match the identification of the applicant. Additional names should be included in the Also Known As line.
3. National MMA ID Card will not be issued unless an accurate and truthful application form is completed in its entirety. Incomplete forms will not be accepted.
4. A color photo including a true likeness of the applicant must be included with the application. The photo shall be of “Passport” type including a clear image with a blank background. No glasses, hats, or other adornments that will obstruct the view of the applicant. (Color digital photos are acceptable).
5. Two forms of valid identification (of which one must include a photo of the applicant) must be included with the application (color digital copies are acceptable). Accepted forms of identification will include; but not be limited to driver’s license, passport, state issued identification, etc.
6. The applicant understands that s/he will not be permitted to compete without a National MMA ID Card.
7. The applicant understands that the ABC in cooperation with the State Athletic Commission will settle any and all disputes with regards to violations of these terms and conditions for the National MMA ID Card. The ruling of the ABC is final and binding on all parties.
8. The applicant agrees to abide by these and any other terms and conditions, rules and regulations set forth by the ABC and the State Commission.
9. The applicant understands and agrees that the ABC reserves the right to amend the terms and conditions for issuing the National MMA ID Card.

I certify that I have read and understand the terms and conditions pertaining to the application for a National MMA ID Card, that all information given is my own, is true and correct to the best of my knowledge. I further understand and agree that false, misstatements or incomplete information on the application will constitute grounds for revoking or denial of the National MMA ID Card, and subject me to a one year suspension at the discretion of the ABC or the State Commission.

APPLICANT SIGNATURE: _____ DATE: _____

Email completed applications and supporting documents to NYSAC@DOS.NY.GOV.

Upon approval of application the applicant will be issued a National ID Number and will be included in the ABC National MMA Database Registry operated by Mixed Martial Arts LLC. The applicant will receive their National MMA ID Card by US Mail in four to six weeks.

Annual Medical Examination form for USMTA competitors

Please book a medical examination with your doctor and bring this form, printed, with you to your appointment. For enquiries contact: usmtainc@gmail.com

Please return all pages of the completed form as a scanned PDF (along with a copy of your blood test results, if their interpretation is included) to: usmtainc@gmail.com

Competitor Name: _____

Medical ID Number *(NHS/CHI Registration number)*: _____

Date of birth: _____

Telephone number: _____

Email address: _____

Postal address: _____

Name of Examining Doctor: _____

Qualifications: _____

Doctor Registration Number: _____

Practice address: _____

Telephone number: _____

Email address: _____

PAST MEDICAL HISTORY

Any hospital admission for medical or surgical reasons? **Yes** ☐ **No** ☐

Date	Summary	Current Status
General Notes		

Allergies? **Yes ☐** **No ☐**

Allergen	Reaction	Hospitalisation	Treatment
General Notes			

Medications? **Yes ☐** **No ☐**

Name	Dose/Frequency	Reason
General Notes		

Has anyone in the family died below the age of 40 due to a heart condition? **Yes ☐** **No ☐**

Relative	Summary of medical conditions	Age of Death
General Notes		

Examination normal? **Yes ☐** **No ☐**

Height (cm)	Weight (kg)	Heart Rate	Systolic BP	Diastolic BP

Additional weight information as reported by fighter: **Yes ☐** **No ☐**

Normal/Walk around weight (kg)	
Weight category for competition (kg/lbs)	

EYES

Pupil: reacting to light Right: Yes ☐ No ☐

Comments if No...	

Pupil: reacting to light Left: Yes ☐ No ☐

Comments if No...	

Fundi: Right normal? Yes ☐ No ☐

Comments if No...	

Fundi: Left normal? Yes ☐ No ☐

Comments if No...	

Visual acuity Right: ____ /6 **Visual acuity Left: ____ /6**

EARS/NOSE/THROAT

Tympanic Membrane Right normal? Yes ☐ No ☐

Comments if No...	

Tympanic Membrane Left normal? Yes ☐ No ☐

Comments if No...	

Hearing: Right normal? Yes ☐ No ☐

Comments if No...	

Hearing: Left normal? Yes ☐ No ☐

Comments if No...	

Teeth: Note condition: Normal? Yes ☐ No ☐

Comments if No...	

NECK

Movements full and pain free? Yes ☐ No ☐

Comments if No...	

CHEST

Rib cage normal? Yes ☐ No ☐

Comments if No...	

Lungs normal? Yes ☐ No ☐

Comments if No...	

Heart Sound: Regular? Yes ☐ No ☐

Comments if No...	

Murmurs? Yes ☐ No ☐

Comments	

Apex: Mid clavicular line 5th intercostal space? Yes ☐ No ☐

Comments if No...	

ABDOMEN

Scars? Yes ☐ No ☐

Comments If Yes	

Enlarged liver or spleen ? Yes ☐ No ☐

Comments If Yes	

BACK

Is movement of the back normal? Yes ☐ No ☐

Comments If No	

LIMBS

Are movements of the limbs normal? Yes ☐ No ☐

Comments If No	

Hands and wrists normal? Yes ☐ No ☐

Comments If No	

NERVOUS SYSTEM

Any tremor ? **Yes ☐** **No ☐**

Comments If Yes	

Romberg test + ? **Yes ☐** **No ☐**

Comments If Yes	

Coordination normal? **Yes ☐** **No ☐**

Comments If Yes	

BLOOD TEST RESULTS

***tick here if NOT interpreting blood test results ☐**

NOTE TO DOCTOR: Please counsel all competitors prior to arranging phlebotomy.
Interpretation must be accompanied by copies of laboratory results sent back with this form.

HEPATITIS B Neg. surface antigen (HBsAg) test required	To be valid, sample must be dated within the 6 months prior to competition	
Date of sample:		**Clear from infection? Yes ☐ No ☐**

HEPATITIS C	To be valid, sample must be dated within the 6 months prior to competition	
Date of sample:		**Clear from infection? Yes ☐ No ☐**

HIV Must inc. p24 antigen and HIV 1+2 antibodies	To be valid, sample must be dated within the 6 months prior to competition	
Date of sample:		**Clear from infection? Yes ☐ No ☐**

CONCLUSION

I confirm that there are no problems found as specified in this medical examination:

Yes ☐ **No ☐**

Signed (Doctor): _____

Print name: _____

Date of examination: _____