

Professional Combatant Dilated Eye Exam

Only a licensed Ophthalmologist or Optometrist may conduct this examination and complete this form. Please complete this form in its entirety.

Full Name: _____

First Name

Middle Name

Last Name

HISTORY

Has applicant ever had any of the following conditions?

1. Blurred vision? [] Yes [] No
2. Surgical procedures done to his/her eye(s) or the tissues around the eye other than simple sutures of the skin around the eye? [] Yes [] No
3. Has applicant had or been informed by a physician that he/she had significant eye problems such as retinal detachment, retinal tear, primary or secondary glaucoma, aphakia, pseudophakia, dislocated lens, or cataract? [] Yes [] No

If yes, please explain: _____

4. Eye Disease? [] Yes [] No

If yes, list nature of diseases: _____

5. Eye Injury? [] Yes [] No

If yes, list nature of injuries: _____

6. Retinal reattachment? [] Yes [] No

If yes, please explain: _____

7. Does the applicant have any other visual condition that would prevent him/her from safely engaging in boxing or martial arts activities? [] Yes [] No

If yes, please explain:

EXAMINATION

Vision: _____
Without glasses
With Glasses

Refraction: If either eye is 20/60 or worse

Right _____ / _____ Right _____ Sph _____ Cyl x _____ Acuity _____
 Left _____ / _____ Left _____ Sph _____ Cyl x _____ Acuity _____



Professional Combatant Physical Examination

If you are 35 years of age or older, you must have a neurological exam.

Only a licensed neurologist or neurosurgeon may conduct this examination and complete this form.

Please complete this form in its entirety.

Participant's Full Name:

First Name

Middle Name

Last Name

PHYSICAL HISTORY: Please check all that apply:

- Asthma Blood in urine Allergies Fainting spells Rupture (hernia)
 - Chest pains Operations Shortness of breath Swollen joints
 - Rheumatism Diabetes Frequent headaches Convulsions (fits)
 - Chronic cough Spitting of blood Cerebral hemorrhage or serious head injury
- If you checked any box, please explain below:

When was the last time you took any type of medication or drug? (State with specificity what type and when):

Have you ever undergone any type of surgery? ____ Yes ____ No (State with specificity what type and when):

When was the last time you took any type of vitamin supplement? (State with specificity what type and when):

General appearance: _____ Height _____ Weight _____ Temperature _____
_____ Disabling scars _____ Mouth _____ Teeth _____
_____ Tonsils _____ Neck _____
_____ Pulse at rest _____ Pulse after 100 hops _____
_____ Blood pressure at rest _____ Blood pressure after 100 hops _____
_____ Blood pressure two (2) minutes later _____

Enlarged glands: [] Yes [] No Goiter: [] Yes [] No

Heart: Pulse rhythm [] Regular [] Irregular Murmurs: [] Yes [] No

Musculoskeletal system: _____

Apical impulse: [] Heavy [] Normal Enlargement: [] Yes [] No

Lungs: Rales [] Yes [] No Abdomen: Enlargement of liver [] Yes [] No

Breasts: Mass [] Yes [] No [] Not Applicable Tenderness [] Yes [] No

Discharge: [] Yes [] No Enlargement of Spleen: [] Yes [] No

Hernia: [] Yes [] No Testicles: Normal [] Yes [] No [] Not Applicable

Reflexes: Pupils _____ Knee jerks _____ Romberg _____ Babinski _____

Skin: Tone _____ Rash _____ Boils _____ Other _____

Unhealed wounds: _____

Remarks: _____

Examining Physician:

Based on your personal observation and review of the test results and considering Commission rules, is it your medical opinion that this applicant is physically fit to be licensed to compete in combative sports? [] Yes [] No If no, please explain:

Licensed Physician's Name _____

Medical License Number _____

Physician's Signature

Date/ Time



Authorization to Use and Disclose Protected Health Information

I hereby authorize _____ (Physician) to furnish to the Tennessee Athletic Commission (the "Commission"), or its successors, copies of all my medical records, hospital records, records of treatment for drug and/or alcohol abuse or dependency, or other information requested by the Commission in connection with my application for licensure by the Commission or any further or future investigation by the Commission necessary to determine my fitness for licensure.

I further authorize the Commission or its successors to release any medical or other personal information with respect to my application or licensure to those athletic commissions (or similar regulatory bodies) that have a need to know, as determined by the Commission. This disclosure of records is required for official use, including investigation of my fitness for licensure by the Commission. I understand that the recipient of my information is not a health plan or health care provider and the released information may no longer be protected by federal privacy regulations.

I understand that I have a right to receive a copy of this authorization if I request it. I may inspect or obtain a copy of the protected health information that I am being asked to disclose. I understand that I have a right to revoke this authorization by sending written notification to the Tennessee Athletic Commission, 500 James Robertson Parkway, Nashville, TN 37243. I understand that if I revoke this authorization, I may not be allowed to continue in the licensure process, or, if I am licensed, my license may be adversely affected.

This authorization shall remain valid for two (2) years from the date a license is issued to me. A copy of this authorization shall be as valid as the original.

Name (Print)

Signature

Date