



PHYSICAL EXAMINATION REPORT FOR BOXER OR MIXED MARTIAL ARTIST

State Form 54475 (R / 3-11)

INDIANA GAMING COMMISSION

INSTRUCTIONS: Only this form or forms created by other Commissions will be accepted in order to satisfy the annual physical requirement. **Both pages** of this completed report must be sent to the Athletic Division or the physical will not be accepted. Examinations can be emailed to iac@igc.in.gov, faxed to (317) 233-0047, or mailed to:

Indiana Gaming Commission
Attention: Athletic Division
101 W. Washington Street
East Tower, Suite 1600
Indianapolis, Indiana 46204

FIGHTER INFORMATION

(to be completed by fighter)

Full name of applicant (*first, middle, last*) _____ Date of birth (*month, day, year*) _____

Address (*number and street, city, state, and ZIP code*) _____

Primary telephone number
() _____

Business telephone number
() _____

Sex Male Female

Height _____

Weight _____

MEDICAL HISTORY

(to be completed by fighter)

Has individual ever had any of the following conditions:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Rupture (hernia) | <input type="checkbox"/> Chest pains | <input type="checkbox"/> Operations |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Swollen joints | <input type="checkbox"/> Spitting of blood | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Convulsions (fits) | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Asthma | <input type="checkbox"/> Allergies | <input type="checkbox"/> Double vision |
| <input type="checkbox"/> Palpitations (racing heart rate) | | <input type="checkbox"/> Cerebral hemorrhage or any other serious head injury | |

Number of knockouts received: _____ Date of last knockout (*month, day, year*): _____

Longest duration of unconsciousness: _____

Length of time before resuming boxing or mixed martial arts after last knockout: _____

Ever knocked unconscious in other sport or in any other way? Yes No

If yes, explain:

Amateur boxing record Wins _____ Losses _____ Draws _____

Professional boxing record Wins _____ Losses _____ Draws _____

Amateur mixed martial arts record Wins _____ Losses _____ Draws _____

Professional mixed martial arts record Wins _____ Losses _____ Draws _____

AFFIRMATION

(to be completed by fighter)

I hereby swear or affirm, under penalties of perjury, that the statements made in this report are true, complete, and correct.

Signature of fighter _____

Printed name of fighter _____

Date (*month, day, year*) _____

PHYSICAL EXAMINATION
(to be completed by examining physician)

Pulse at rest: _____

Pulse after 100 hops: _____

Blood pressure at rest: _____

Blood pressure after 100 hops: _____

Glands

Enlarged? Yes No

Goiter Yes No

Heart

Pulse rhythm Regular Irregular

Apical impulse Heavy Normal

Enlargement? Yes No

Murmurs? Yes No

Lungs

Rales? Yes No

Breasts

Mass? Yes No

Tenderness? Yes No

Discharge? Yes No

Abdomen

Enlargement of liver? Yes No

Enlargement of spleen? Yes No

Hernia? Yes No

If yes: Femoral Inguinal Ventral

Remarks:

Testicles

Normal? Yes No

Remarks:

Reflexes

Pupils: _____

Knee jerks: _____

Romberg: _____

Babinski: _____

Skin

Rash: _____

Boils: _____

Any other unhealed wounds: _____

Remarks for specified medical clearances:

Medications:

Physician MUST check one of the boxes below:

I HAVE

I HAVE NOT

medically cleared this fighter to compete in boxing and/or mixed martial arts.

Physician's signature

Physician's name and license number

Date (month, day, year)

Physician's business address (number and street, city, state, and ZIP code)

Business telephone number
()