Reset Form

# PHYSICAL EXAMINATION REPORT FOR BOXER OR MIXED MARTIAL ARTIST

State Form 54475 (R2 / 1-20)
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 e-mailed 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:

| | | | |
|---|---|---|---|
| ☐ Fainting spells | ☐ Rupture (hernia) | ☐ Chest pains | ☐ Operations |
| ☐ Shortness of breath | ☐ Swollen joints | ☐ Spitting of blood | ☐ Diabetes |
| ☐ Frequent headaches | ☐ Convulsions (fits) | ☐ Chronic cough | ☐ Rheumatis |
| ☐ Bleeding disorder | ☐ Asthma | ☐ Allergies | ☐ Double vision |
| ☐ Palpitations (racing heart rate) | | ☐ 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 Stamp:**

| 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 ( ) | Business fax number ( ) |
|---|---|---|
| | | |