



CALIFORNIA AMATEUR MIXED MARTIAL ARTS ORGANIZATION, INC.

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AMATEUR ATHLETE PHYSICAL EXAMINATION

APPLICANT NAME	RING NAME	TELEPHONE	DATE OF BIRTH

ADDRESS	CITY	STATE	ZIP CODE	COUNTRY

PHYSICAL HISTORY: Have you ever had any of the following conditions?:

- | | | |
|---|--|---|
| ☐ None | ☐ Rupture (hernia) | ☐ Chest pains |
| ☐ Fainting spells | ☐ Shortness of breath | ☐ Swollen joints |
| ☐ Operations | ☐ Diabetes | ☐ Frequent headaches |
| ☐ Rheumatism | ☐ Chronic cough | ☐ Spitting of blood |
| ☐ Convulsions (fits) | | |
| ☐ Cerebral hemorrhage or serious head injury | | |

Please Explain: _____

Number of knockout losses in your career: _____ **Date of last knockout:** _____

Have you ever suffered a loss of consciousness for any reason?: ☐ NO ☐ YES

If YES, please explain and provide date(s) and location(s): _____

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

Have you ever undergone any type of surgery? ☐ No ☐ Yes If YES, please describe (State what type and when): _____

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

Amateur record: Wins _____ Losses _____ Draws _____
Professional boxing/kickboxing: Wins _____ Losses _____ Draws _____
Additional information: _____

PHYSICAL EXAMINATION (ALL FIELDS REQUIRED):

General appearance: _____	Height: _____	Weight: _____	Temperature: _____
Disabling scars: _____	Mouth: _____	Teeth: _____	Tonsils: _____
Pulse at rest: _____	Pulse after 100 hops: _____		Neck: _____
Blood pressure: At rest: _____	After 100 hops: _____	2 minutes later: _____	
Heart Pulse Rhythm: ☐ Regular ☐ Irregular	Lungs: Rales ☐ No ☐ Yes		
Murmurs: ☐ No ☐ Yes	Goiter: ☐ No ☐ Yes		
Apical impulse: ☐ Normal ☐ Heavy	Enlarged glands: ☐ No ☐ Yes		
Enlargement: ☐ No ☐ Yes	Testicles: Normal ☐ Yes ☐ No		
Breasts: Tenderness ☐ No ☐ Yes	Hernia: ☐ No ☐ Yes		
Breasts: Mass ☐ No ☐ Yes	Abdomen: Enlargement of liver ☐ No ☐ Yes		
Breasts: Discharge ☐ No ☐ Yes	Enlargement of Spleen: ☐ No ☐ Yes		

Remarks: _____

Reflexes: Pupils _____ Knee jerks _____ Romberg _____
Babinski _____ Skin: Tone _____ Rash _____ Boils _____ Other: _____

Unhealed wounds: _____

Remarks: _____

EYE HISTORY: Have you ever had any of the following conditions:

Blurred vision? ☐ **No** ☐ **Yes** – If YES, please explain in full:

Have you ever had any surgical procedures done to your eye(s) or the tissues around your eye(s) other than simple sutures of the skin around the eye? ☐ **No** ☐ **Yes** – If YES, please explain in full:

Have you ever been diagnosed by a physician to have significant eye problems such as retinal detachment, retinal tear, primary or secondary glaucoma, aphakia, pseudophakia, or dislocated lens? ☐ **No** ☐ **Yes** – If YES, please explain in full:

EXAMINING PHYSICIAN:

I have examined the above named applicant and I **DO NOT FIND** a condition that would preclude him/her from being licensed as amateur mixed martial arts athlete.

Authorization for release of medical information is attached.

*LICENSED PHYSICIAN'S NAME (print)

*MEDICAL LICENSE NUMBER

ADDRESS

CITY

STATE

ZIP CODE

TELEPHONE NUMBER

APPOINTMENT DATE/TIME (Form incomplete if left blank)

PHYSICIAN'S SIGNATURE (MD or DO ONLY*)

*Must be a licensed physician (**MD or DO ONLY**). No physician assistant (PA) or nurse (NP) signatures accepted without accompanying physician name, signature, and medical license number.

Please note: Athletes who are **40 years of age or older must also complete the separate **ATHLETE 40+ MEDICAL PACKET** in full.

Submission Instructions:

- Ensure **ALL** fields are completed with the physician in full prior to submission or the submission will be denied.
- Appointment dates are required. Undated medicals will be considered incomplete.
- Submit completed medicals to **1-888-663-9915** or e-mail to **medicals@camomma.org** for processing.