



# THE COMMONWEALTH OF MASSACHUSETTS STATE ATHLETIC COMMISSION

PLEASE SUBMIT APPLICATION TO:  
**50 MAPLE STREET . MILFORD, MASSACHUSETTS 01757**

## APPLICATION FOR FIGHTER'S LICENSE

(Please Type or Print Legibly)  
(Illegible or incomplete applications will not be accepted)

Please check sport which you are seeking Licensure:

BOXING

MMA

UNARMED COMBATANT: \_\_\_\_\_

PROFESSIONAL

AMATEUR

### BACKGROUND INFORMATION

NAME \_\_\_\_\_  
First Middle Initial Last

ADDRESS \_\_\_\_\_  
Street City State Zip

DAYTIME TELEPHONE # (\_\_\_\_\_) \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

DATE OF BIRTH \_\_\_\_ / \_\_\_\_ / \_\_\_\_ PLACE OF BIRTH \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_ OCCUPATION \_\_\_\_\_

EMPLOYER'S NAME \_\_\_\_\_

EMPLOYER'S ADDRESS \_\_\_\_\_  
Street City State Zip

EMPLOYER'S TELEPHONE # (\_\_\_\_\_) \_\_\_\_\_

HEIGHT \_\_\_\_\_ PRESENT WEIGHT \_\_\_\_\_

AMATEUR RECORD \_\_\_\_\_ PROFESSIONAL RECORD \_\_\_\_\_

NAME AND ADDRESS OF TRAINER \_\_\_\_\_

DO YOU PRESENTLY SUFFER FROM ANY KNOWN MEDICAL CONDITION THAT WOULD MAKE IT UNSAFE FOR YOU TO ENGAGE IN AN UNARMED COMBATIVE SPORTING EVENT?  YES  NO

HAVE YOU EVER BEEN HOSPITALIZED DUE TO AN UNARMED COMBAT RELATED INJURY? IF YES, PLEASE ATTACH A WRITTEN EXPLANATION.  YES  NO

**THE FOLLOWING ITEMS MUST ACCOMPANY THIS APPLICATION**

**(check box indicating compliance):**

- \$75 application fee for professional fighters (no fee for amateur fighters until further notice)
- Two passport photographs (2" x 2" in size) of the applicant's head (without headwear) **FOR NON-RESIDENTS**
- Copy of a government issued photo identification (e.g.- driver's license)
- Copy of birth certificate
- Record of Medical Examination form
- (For Professional and Amateur fighters who have never been licensed in Massachusetts) Debut Form

**AUTHORIZATION FOR RELEASE OF RMV INFORMATION – FOR MA RESIDENTS**

My signature below authorizes the Department of Public Safety to electronically access my photograph from the Massachusetts Registry of Motor Vehicles database solely for use on this license/registration.

\_\_\_\_\_  
MA- RMV photo release signature

(OPTIONAL)

**\Please check here if English is not your primary language AND your ability to read, write, speak, or understand English is limited. If you checked the box, please indicate what your primary language is:**

Arabic	Chinese	French	German	Italian	Korean	Polish
Portuguese	Russian	Spanish	Tagalog	Vietnamese	Other _____	

**ATTESTATION**

*I hereby attest, under the pains and penalties of perjury, that the information provided above is true and accurate to the best of my knowledge. Further, I certify that I have filed all required tax returns and paid all state taxes as required by law.*

\_\_\_\_\_  
Signature of applicant

\_\_\_\_\_  
Date

**FOR COMMISSION USE ONLY**

DATE OF COMMISSION REVIEW: \_\_\_\_\_

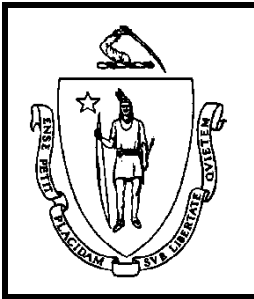
APPROVED \_\_\_\_\_ DENIED \_\_\_\_\_

DATE LICENSE MAILED: \_\_\_\_\_

REASON FOR DENIAL:

Rev. 4/11





**THE COMMONWEALTH OF MASSACHUSETTS**  
**DEPARTMENT OF PUBLIC SAFETY**  
**STATE ATHLETIC COMMISSION**

PLEASE SUBMIT APPLICATION TO:  
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**RECORD OF MEDICAL EXAMINATION**  
(MUST BE COMPLETED WITHIN THIRTY DAYS OF  
SUBMISSION OF APPLICATION FOR LICENSURE)

**BACKGROUND**

FIGHTER'S NAME: \_\_\_\_\_ FIGHTER'S D/O/B: \_\_\_\_\_  
DATE OF EXAMINATION: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_  
NAME OF EXAMINING PHYSICIAN: \_\_\_\_\_  
ADDRESS OF PHYSICIAN: \_\_\_\_\_  
TELEPHONE # OF PHYSICIAN: \_\_\_\_\_  
STATE IN WHICH PHYSICIAN IS LICENSED TO PRACTICE MEDICINE: \_\_\_\_\_

**INSTRUCTIONS**

All applicants for licensure as an unarmed combatant in Massachusetts must undergo a complete physical examination, including neurological and cardiac testing, by a licensed physician. The examination must include a review by the physician of the medical records identified below. Applicants should be in excellent health at the time of the examination in order for the examining physician to approve of licensing the individual. This form must be completed by the examining physician and given to the applicant so that it may be submitted to the Commission along with their application for licensure as an unarmed combatant. The physical examination and corresponding review of medical documentation may not take place more than thirty days prior to the submission of an application.

**MEDICAL HISTORY**

Has this individual ever suffered a concussion?     YES    NO  
If yes, please provide date(s) and circumstances: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does this individual wear contact lenses?  YES  NO

Has this individual undergone LASIK eye surgery?  YES  NO

(If yes, clearance to fight must be obtained from an optometrist or ophthalmologist prior to licensure.)

Please identify any present medical issues or past conditions you believe the Commission should be aware of in determining whether to license this individual as a professional combatant:

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### REVIEW OF MEDICAL RECORDS

The examining physician must review the records identified below and check the box indicating that the review has been performed. Please ensure that the examinations were performed within **30 days** of the review. The reviewing physician must be left satisfied that the records are authentic. The reviewed medical records must be attached to this form and submitted to the Commission.

- RECORD OF PHYSICAL EXAMINATION PERFORMED IN CONJUNCTION WITH THIS REVIEW
- EVIDENCE OF AN ASYMPTOMATIC ELECTROCARDIOGRAM (EKG) WITHIN **30 DAYS** PRECEDING THE DATE OF THE EXAMINATION
- EVIDENCE OF A NEGATIVE TEST FOR HIV, HEPATITIS BsAG, AND HEPATITIS CAB WITHIN **30 DAYS** PRECEDING THE DATE OF THE EXAMINATION
- EVIDENCE OF AN ASYMPTOMATIC DILATED EYE EXAMINATION BY AN OPTOMETRIST OR OPHTHALMOLOGIST WITHIN **30 DAYS** PRECEDING THE DATE OF THE EXAMINATION
- (IF APPLICABLE) (NOT REQUIRED FOR INDIVIDUALS APPLYING FOR AN AMATEUR LICENSE) EVIDENCE OF AN ASYMPTOMATIC BRAIN CT, BRAIN MRI, OR NEUROLOGICAL EXAMINATION PERFORMED BY A NEUROLOGIST OR NEUROSURGEON WITHIN **5 YEARS** PRECEDING THE DATE OF EXAMINATION (INDIVIDUALS 35 YEARS OF AGE AND OLDER ARE REQUIRED)

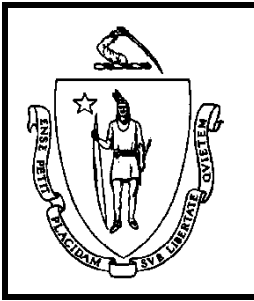
### PHYSICIAN ATTESTATION

*I hereby attest that I have examined the above named individual and reviewed all of the medical records identified above. I am aware that this individual seeks to be licensed as an unarmed combatant. In my medical opinion this individual does not suffer from any known conditions which should prevent them from competing and is otherwise presently fit to be licensed as an unarmed combatant.*

\_\_\_\_\_  
NAME OF PHYSICIAN (PRINT)

\_\_\_\_\_  
SIGNATURE OF PHYSICIAN

\_\_\_\_\_  
DATE



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**DEBUT IN MASSACHUSETTS FORM**

**BIOGRAPHICAL INFORMATION**

NAME OF FIGHTER: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

HEIGHT: \_\_\_\_\_ PRESENT WEIGHT: \_\_\_\_\_

AMATEUR RECORD: \_\_\_\_\_ PROFESSIONAL RECORD: \_\_\_\_\_

NAME AND ADDRESS OF TRAINER: \_\_\_\_\_  
\_\_\_\_\_

(FOR MMA FIGHTERS) TEAM: \_\_\_\_\_

NAME AND ADDRESS OF MANAGER (IF ANY): \_\_\_\_\_  
\_\_\_\_\_

SPORT FOR WHICH YOU ARE SEEKING LICENSURE:  BOXING  MMA  UNARMED COMBATANT

DISCIPLINE: \_\_\_\_\_

**EXPERIENCE**

AMATEUR RECORD: \_\_\_\_\_  ATTACH RESULTS LIST OF ALL AMATEUR FIGHTS

PROFESSIONAL RECORD: \_\_\_\_\_  ATTACH RESULTS LIST OF ALL PRO FIGHTS

-OTHER STATES IN WHICH YOU HAVE BEEN LICENSED: \_\_\_\_\_  
\_\_\_\_\_

LENGTH OF TRAINING PERIOD FOR PRESENT MATCH: \_\_\_\_\_

**ATTESTATION**

**TWO** INDIVIDUALS WITH PERSONAL KNOWLEDGE MUST ATTEST AS TO THE FITNESS OF THE FIGHTER TO PARTICIPATE IN A MATCH BY COMPLETING THE SECTION BELOW. ONE OF THESE INDIVIDUALS MUST BE THE FIGHTER'S TRAINER.

**1. I,** \_\_\_\_\_, HEREBY SWEAR OR ATTEST UNDER THE PAINS AND PENALTIES OF PERJURY THAT IN MY OPINION THE ABOVE NAMED FIGHTER HAS THE NECESSARY SKILLS AND IS OTHERWISE FIT TO COMPETE IN A PROFESSIONAL \_\_\_\_\_ MATCH.  
(INSERT SPORT)

-RELATIONSHIP TO FIGHTER: **TRAINER**

-MA TRAINER'S LICENSE#: \_\_\_\_\_

-LENGTH OF TIME KNOWN FIGHTER: \_\_\_\_\_

-PHONE #: (\_\_\_\_\_) \_\_\_\_\_ -EMAIL: \_\_\_\_\_

-ADDRESS: \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

**2. I,** \_\_\_\_\_, HEREBY SWEAR OR ATTEST UNDER THE PAINS AND PENALTIES OF PERJURY THAT IN MY OPINION THE ABOVE NAMED FIGHTER HAS THE NECESSARY SKILLS AND IS OTHERWISE FIT TO COMPETE IN A PROFESSIONAL \_\_\_\_\_ MATCH.  
(INSERT SPORT)

-RELATIONSHIP TO FIGHTER: \_\_\_\_\_

-MA TRAINER'S LICENSE#: \_\_\_\_\_

-LENGTH OF TIME KNOWN FIGHTER: \_\_\_\_\_

-PHONE #: (\_\_\_\_\_) \_\_\_\_\_ -EMAIL: \_\_\_\_\_

-ADDRESS: \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE