New York State
**Department of State**
**State Athletic Commission**
123 William Street
New York, NY 10038-3804
Telephone: (212) 417-5700
www.dos.ny.gov/athletic

# New York State Athletic Commission

## PHYSICIAN'S EXAMINATION

**SECTION 1 — TO BE COMPLETED BY BOXER**

| 1. LEGAL NAME | 2. RING NAME | |
|---|---|---|
| 3. FEDERAL ID NUMBER | 4. DATE OF BIRTH | 5. TELEPHONE NUMBER |
| 6. BOXER'S ADDRESS | | 7. EMAIL ADDRESS |

8. Have you ever been knocked out? . . . . . ☐ YES* ☐ NO
   ***If YES, date last time***: _____

9. Enter date and results of last bout: _____

10. Are you suffering from headaches, blurring of vision or dizziness? . . . . . ☐ YES* ☐ NO

11. Are you suffering from any hand injury? . . . . . ☐ YES* ☐ NO

12. Have you suffered any injury during the past year? . . . . . ☐ YES* ☐ NO

13. Have you consulted any doctor for any medical condition during the past year? . . . . . ☐ YES* ☐ NO

14. Have you taken any medications, supplements or drugs during the past 30 days? ☐ YES* ☐ NO
   ***If Yes, please list:*** _____

   _____

15. Do you wish to provide any other information concerning your health — ***past*** and ***present***?. . . . . ☐ YES* ☐ NO
   ***If YES to Items 8-15, please explain***:

   _____

   _____

   _____

   _____

16. GYM NAME _____ PHONE _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

**Applicant Certification** — I understand that the examining physician depends on the reliability of the statements I made above and that deliberate misstatements will subject me to disciplinary action by the New York State Athletic Commission. Further, I hereby certify that the above statements are true and correct to the best of my knowledge and belief. I further understand that all statements and information supplied by me are made under the penalty of perjury and, if untrue and not informative, will lead to penalty and/or suspension.

**X** _____ _____

*Boxer's Signature* *Date*

## SECTION 2 — PHYSICAL EXAMINATION — TO BE COMPLETED BY EXAMINING PHYSICIAN

1. ORAL TEMPERATURE (if indicated)

2. HEIGHT

3. WEIGHT

4. EYES — PUPILS: REACT TO LIGHT & ACCOMMODATION

SNELLEN CHART VISION (UNCORRECTED) RIGHT LEFT

CORNEA _____ CONJUNCTIVA _____

5. PERIORBITAL REGIONS (Describe scars, if any)

6. OROPHARYNX

EARS (Discharge, etc.)

7. LUNGS (Specify any abnormal breath sounds, friction rub, rales, etc.)

8. HEART RATE

ANY IRREGULARITY

MURMURS

9. A) BLOOD PRESSURE

B) PULSE (at rest)

C) PULSE (after 20 hops)

D) PULSE (2 minutes after exercise)

10. ABDOMEN (masses, spasms, tenderness, hernias)

INGUINAL REGION (masses, tenderness, other joint injuries)

11. VERTEBRAL COLUMN (Stiffness and tenderness)

12. EXTREMITIES (Stiffness, swelling, tenderness, other joint injuries)

13. NERVOUS SYSTEM — GAIT TREMORS RHOMBERG KNEE JERKS FINGER TO NOSE

*Signature of NYSAC Approved Physician* **X** _____ *Date* _____

PRINT Name and Office Address _____

_____

## DIAGNOSTIC EVALUATION

| | Brain Scan | EKG | CBC/PT-INR/PTT | Eye Exam | HIV | HBSAG | HCAB |
|---|---|---|---|---|---|---|---|
| DATE | | | | | | | |
| RESULT | | | | | | | |

*Physician's Signature* **X** _____ *Date* _____