



APPLICATION FOR BOXER LICENSE RENEWAL

Read the instructions carefully before completing the application. Incomplete applications will be returned, delaying licensure. Any omission, inaccuracy or failure to make full disclosure in an application or supporting documentation may be deemed sufficient reason to deny a license, or, if a license is issued could result in the suspension or revocation of a license.

Who should complete this form?

This form should be completed by professional boxers who are renewing a license which is about to expire or a license which is already expired.

What forms of payment do you accept?

You may pay by check or money order made payable to the: "NYS Athletic Commission" in the amount of \$10. A \$20 fee will be charged for any check returned by your bank. **DO NOT SUBMIT CASH WITH YOUR APPLICATION.** License fees may also be deducted from your purse at a weigh-in.

When can I renew for a license?

In order to renew a license you must first be scheduled to appear on a professional boxing card and pass rigorous medical exams, accordingly, you should not submit this application until you have been conditionally approved to box by the Commission.

Do I need to submit new fingerprints?

Possibly. If you have not been licensed for an extended period of time and/or have not renewed for too many consecutive years you may need to submit new fingerprints. The Commission will advise you if you need to resubmit fingerprints.

How long is my renewal valid for?

All licenses issued by the Commission, including renewals, are valid until the next September 30th following the date of issue.

I have different licenses, do I have to complete this form to renew my other licenses?

No, you must submit a new form for each type of license you are trying to renew. You must also submit a separate payment for each type of license.

Do I need to complete the Child Support Statement section of the application?

Yes, a Child Support Statement is mandatory in New York State (General Obligations Law). The law requires you to complete this section — regardless of whether or not you have children or any support obligation.

Any person who is four months or more in arrears in child support may be subject to having his or her business, professional and driver's licenses suspended.

The intentional submission of a false written statement for the purpose of frustrating or defeating the lawful enforcement of support obligations is punishable under §175.35 of the Penal Law. It is a class E felony to offer a false instrument for filing with a state or local government with the intent to defraud.

PRIVACY NOTIFICATION

Do I need to provide my Social Security number on the application?

Yes. The State Athletic Commission is required to collect the Social Security numbers of all licensees. The authority to request and maintain such personal information is found in §5 of the Tax Law and §3-503 of the General Obligations Law. Disclosure by you is mandatory. The information is collected to enable the Department of Taxation and Finance to identify individuals, businesses and others who have been delinquent in filing tax returns or may have underestimated their tax liabilities and to generally identify persons affected by the taxes administered by the Commissioner of Taxation and Finance. It will be used for tax administration purposes and any other purpose authorized by the Tax Law and may also be used by child support enforcement agencies or their authorized representatives of this or other states established pursuant to Title IV-D of the Social Security Act, to establish, modify or enforce an order of support, but will not be available to the public. A written explanation is required where no number is provided. This information will be maintained in the Licensing Information System by the Commission, at 123 William Street, New York, NY 10038-3804.

PLEASE DO NOT RETURN THIS COVER PAGE WITH YOUR APPLICATION. - THANK YOU -



APPLICATION FOR BOXER LICENSE RENEWAL

**Read the instructions before completing this application.
You must answer each question and PRINT responses in ink.**

APPLICANT'S NAME	LAST	FIRST	MI	SUFFIX
APPLICANT'S HOME ADDRESS — NUMBER AND STREET (P.O. BOX MAY BE ADDED TO ENSURE DELIVERY)				
CITY		STATE	ZIP + 4	
COUNTY		COUNTRY		
SOCIAL SECURITY NUMBER (See Privacy Notification)		DATE OF BIRTH (month, day, year) MM / DD / YYYY	DAYTIME PHONE (REQUIRED; if problem with application)	
E-MAIL ADDRESS (REQUIRED)				

Background Information — *You must complete this section. If you do not complete it, your application will be returned.*

1. Since your last application, have you been convicted of a crime or offense (not minor traffic violation), in this state or elsewhere or has any license, permit, commission, registration or application for a license, permit, commission or registration - not solely related to boxing - held by or submitted by you or a company in which you are or were a principal been revoked, suspended, or denied by any state, territory or governmental jurisdiction or foreign country for any reason? **Yes** **No**
→IF “YES,” (If yes, enclose details)

2. Are there any criminal charges (misdemeanor or felony) - not solely related to boxing - pending against you in any court in this state or elsewhere? If yes, you must submit a copy of the accusatory instrument (e.g. indictment, criminal information or complaint).
Yes **No**
→IF “YES,” (If yes, enclose details)

Professional Boxing Information — *You must complete this section. If you do not complete it, your application will be returned.*

1. At what gym are you currently training? (provide name, address and phone number of gym):
.....
.....

2. Manager's name (if applicable):
3. Manager's address and telephone:
4. Name of trainer (if applicable):
5. Name of Promoter (if applicable):

continued on next page

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Child Support Statement — *You must complete this section. If you do not complete it, your application will be returned.*

“X” A or B, below

I, the undersigned, do hereby certify that (You *must* “X” A or B, below):

- A. **I am not under obligation to pay child support.** (SKIP “B” and go directly to Applicant Affirmation).
- B. I am under obligation to pay child support (You must “X” any of the four statements below that are true and apply to you):
- I do *not* owe four or more months of child support payments.
 - I am making child support payments by income execution or court approved payment plan or by a plan agreed to by the parties.
 - My child support obligation is the subject of a pending court proceeding.
 - I receive public assistance or supplemental social security income.
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Applicant Affirmation — I subscribe and affirm under the penalties of perjury that the statements made in this application (including statements made in any accompanying papers) have been examined by me, and to the best of my knowledge and belief, are true and correct. I understand that any misstatement made on this application for approval could result in disciplinary action, including but not limited to: suspension, revocation and/or fines.

“HEALTH AND SAFETY DISCLOSURE”

As per the Muhammad Ali Boxing Reform Act (15 USC § 6305[c] [2000]), it is the sense of Congress that each boxing commission should present to every professional boxer a health and safety disclosure upon issuance of a Federal Identification Card. In addition to such disclosure, the New York State Athletic Commission believes that it is in the best interest of boxing to include a health and safety disclosure with every professional boxer license application filed in the State of New York.

As a professional boxer you should be aware that this sport includes many health and safety risks, including but not limited to the risk of brain injury. Therefore, is it strongly recommended that every professional boxer periodically undergo the necessary medical exams and procedures that detect brain injury. In connection with this license application, certain specific medical exams and procedures intended to detect brain injury and other medical conditions contraindicated for professional boxing may be required by the State Athletic Commission. If you need further information about these exams, please contact the New York State Athletic Commission.

I affirm that I understand the above statement.

Applicant’s Signature

X _____ *Date:* _____

IF YOU ARE APPLYING FOR A LICENSE AND WOULD LIKE A PHYSICAL LICENSE MAILED TO YOU CHECK THIS BOX :

Please remember to include with this form any required explanations and the appropriate fee (if by check, money order payable to: NYS Athletic Commission).

FOR COMMISSION USE ONLY:

License Number: _____

Boxer Medical Releases and Disclosure Sections-

(Information provided in Part B will be maintained in each boxer's medical file)

**NEW YORK STATE ATHLETIC COMMISSION
DRUG ABUSE AND STEROID POLICY**

- I. The New York State Athletic Commission (NYSAC) requires that every boxer, as part of his/her medical examination, submit to a drug and/or steroid screening through a urinalysis.**
- II. Use of controlled substances, as defined by the New York Penal Law and Public Health Law, are forbidden and may lead disciplinary action, including but not limited to: suspension, revocation, forfeiture of purse, modification of a boxing result and/or fines. Such penalties may be imposed upon any licensee or permit holder responsible for the abuse of such drugs and/or illicit substances as determined by NYSAC.**
- III. If any prohibited drugs and/or substances are detected such boxer may be precluded from boxing within the State and have the results of any such previous bout modified to a "no contest."**
- IV. In addition to any administrative penalties, any boxer testing positive for a violation of NYSAC's drug abuse and steroid policy shall be suspended medically and may not compete in this State or elsewhere until the boxer has been medically cleared by NYSAC's medical staff.**
- V. The boxer acknowledges and understands that NYSAC will vigorously enforce and seek appropriate sanctions for any violations of this policy.**

Boxer Affirmation - I subscribe and affirm under the penalties of perjury that I have reviewed the policy on prohibited drugs and/or illicit substances and that I am not currently using any prohibited drugs and/or illicit substances.

Boxer Name: _____

Boxer Signature: _____

Date: _____

-This section intentionally left blank-

MEDICAL INFORMATION RELEASE
**AUTHORIZATION TO DISTRIBUTE MEDICAL INFORMATION
TO ALL MEMBER COMMISSIONS AFFILIATED WITH
THE ASSOCIATION OF BOXING COMMISSIONS (ABC)**

I, hereby authorize the New York State Athletic Commission to release, disclose and furnish to any other commission or program affiliated with the Association of Boxing Commissions (ABC), including its official record keeper, any and all of my medical records obtained by the New York State Athletic Commission concerning my licensure as a boxer including, but not limited to, annual physical examinations, ophthalmological examinations, neurological examinations, negative tests for the HIV virus, Hepatitis B virus, and Hepatitis C virus, drug testing, hospital records, and any other information regarding conditions related to the propriety of my licensure as a boxer (including history, findings, diagnosis and prognosis).

I understand, and it is agreed, that the signing of this Medical Information Release is optional, and that my declining to sign this document will not result in any adverse action being taken against me by the New York State Athletic Commission or any of the member commissions affiliated with the ABC.

I understand, and it is agreed, that the medical records described herein will not be released for any purpose other than for the purpose of a member commission affiliated with the ABC determining my eligibility to participate in boxing.

I understand, and it is agreed, that this authorization shall remain in effect for a period of one year from the date it is signed, and is relevant to all medical records described herein whether such records were created prior to, or subsequent to, the date the authorization is signed.

PRINTED NAME OF BOXER

BOXER'S FEDERAL I.D. #

SIGNATURE OF BOXER

DATE SIGNED

-This section intentionally left blank-

NEW YORK STATE ATHLETIC COMMISSION

DOS 1893 (12/09)

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	Date of Birth	Social Security Number
Patient Address		Patient Telephone Number

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

- This authorization may include disclosure of information relating to **ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
- If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (718) 741-8400 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
- I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
- I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
- Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
- THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:
New York State Athletic Commission, 123 William St., 20th Floor, New York, NY 10038

9(a). Specific information to be released:

Medical Record from (insert date) _____ to (insert date) _____

Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

Other: _____ Include: (Indicate by Initialing)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) By initialing here _____ I authorize _____

Initials Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

New York State Athletic Commission

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: <input checked="" type="checkbox"/> At request of individual <input type="checkbox"/> Other:	11. Date or event on which this authorization will expire: One year from this date
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12. If not the patient, name of person signing form: N/A	13. Authority to sign on behalf of patient: N/A
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All items on this form have been completed and my questions about this form have been answered in addition, I have been provided a copy of the form.

 (Signature of patient or representative authorized by law)

Date: _____

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**