New York State
Department of State
State Athletic Commission
P.O. Box 22090
Albany, NY 12201-2001
Fax: (518) 474-3795
www.dos.ny.gov/athletic

NEW YORK STATE OF OPPORTUNITY.

New York State Athletic Commission

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

History and Physical Examination Record for a License as a Judge or Referee

SECTION 1 — TO BE COMPLETED BY APPLICANT FOR A JUDGE OR REFEREE LICENSE

**** Please note that referees are also required to submit an EKG tracing, Hepatitis B Surface Antigen, Hepatitis C Antibody and HIV blood tests along with their application ****

1. LEGAL NAME	2. HOME TELEPHONE NUMBER	3. BUSINESS TELEPHONE NUMBER

4. STREET ADDRESS (HOME)

CITY	STATE	ZIP CODE + 4

5. DATE OF BIRTH	6. *FROM BACKGROUND INFORMATION

7. Have you ever served in the U.S. Armed Services?..... ❑ **YES*** ❑ **NO**
   *If you received a medical discharge, state reason:

8. Do you suffer from shortness of breath, pounding (palpitation) of the heart, any pain or pressure in the chest, or have you ever been told that you had any disease of the heart?..... ❑ **YES*** ❑ **NO**
   *If YES, explain:

9. Have you ever spat blood or been told that you have any disease of the lung?..... ❑ **YES*** ❑ **NO**
   *If YES, explain:

10. Have you ever been advised to have any special examinations such as X-rays, electrocardiograms, electroencephalograms, blood examinations, etc.? ..... ❑ **YES*** ❑ **NO**
    *If YES, explain:

11. Have you ever fractured any bones or suffered any back, neck or other injury? ..... ❑ **YES*** ❑ **NO**
    *If YES, explain:

12. Have you had any illness, disease, accident or surgical operation within the past five years?..... ❑ **YES*** ❑ **NO**
    *If YES, explain:

13. Have you any other information concerning your health — **past and present** — which has not been covered by the above questions?..... ❑ **YES*** ❑ **NO**
    *If YES, explain:

Comments, if any:

❑✓ box if additional comments on back

Applicant Certification — 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 _____ _____
Applicant Signature *Date*

X _____ _____
Physician's Signature *Date*

X _____ _____
Reviewed by (Physician) *Date*

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SECTION 2 — JUDGE/REFEREE PHYSICAL EXAMINATION — TO BE COMPLETED BY EXAMINING PHYSICIAN

1. VITAL SIGNS

A) BLOOD PRESSURE	B) PULSE (AT REST)	C) PULSE (AFTER 20 HOPS)	D) PULSE (2 MINUTES AFTER EXERCISE)

COMMENT

2. HEAD AND FACE (Describe scars, swelling, tenderness, etc.) ❑ NORMAL ❑ ABNORMAL ❑ NOT EXAMINED

3. EYES (to be completed by an optometrist)

A) RETINA ❑ NORMAL ❑ ABNORMAL ❑ NOT EXAMINED

B) CORNEA AND CONJUNCTIVEA ❑ NORMAL ❑ ABNORMAL ❑ NOT EXAMINED

C) VISUAL ACUITY (SNELLEN CHART)

UNCORRECTED: RIGHT _____ LEFT _____

CORRECTED: RIGHT _____ LEFT _____

Optometrist Signature: X _____ **Date:** _____

4. EARS (Including tympanic membrane, external auditory canals, auditory acuity for conversational voice) ❑ NORMAL ❑ ABNORMAL ❑ NOT EXAMINED

5. NOSE ❑ NORMAL ❑ ABNORMAL ❑ NOT EXAMINED

6. OROPHARYNX ❑ NORMAL ❑ ABNORMAL ❑ NOT EXAMINED

7. NECK ❑ NORMAL ❑ ABNORMAL ❑ NOT EXAMINED

8. LUNGS ❑ NORMAL ❑ ABNORMAL ❑ NOT EXAMINED

9. THORAX/CHEST ❑ NORMAL ❑ ABNORMAL ❑ NOT EXAMINED

10. HEART ❑ NORMAL ❑ ABNORMAL ❑ NOT EXAMINED

11. ABDOMEN and INGUINAL AREA ❑ NORMAL ❑ ABNORMAL ❑ NOT EXAMINED

12. BACK and SPINE ❑ NORMAL ❑ ABNORMAL ❑ NOT EXAMINED

SECTION 2 CONTINUED— TO BE COMPLETED BY EXAMINING PHYSICIAN

13. EXTREMITIES/MUSCULOSKELETAL SYSTEM ❑ NORMAL ❑ ABNORMAL ❑ NOT EXAMINED

14. SKIN ❑ NORMAL ❑ ABNORMAL ❑ NOT EXAMINED

15. LYMPHATIC SYSTEM ❑ NORMAL ❑ ABNORMAL ❑ NOT EXAMINED

16. NERVOUS SYSTEM ❑ NORMAL ❑ ABNORMAL ❑ NOT EXAMINED

SUMMARIZE ALL POSITIVE FINDINGS, IF ANY, AND INDICATE YOUR CLINICAL INTERPRETATION OF THIS DATA

RECOMMENDATIONS FOR FURTHER SPECIALIZED EXAMINATION AND/OR CONSULTATION

OTHER REMARKS

Physician's Certification — I hereby certify that I have examined (*print full legal and ring name of applicant*)

on this day, (insert date) _____, and I ❑ **Approve** ❑ **Disapprove** this applicant for Judge/Referee

Name of Physician (PRINT): _____

Signature of Physician: **X** _____

Office Address: _____

If physical was not conducted at the office listed above, specify location/address:

Office Telephone Number: _____