COMMONWEALTH OF PENNSYLVANIA
STATE ATHLETIC COMMISSION

PHYSICIAN'S EXAMINATION - DATE: _____

BOXER'S/MMA Fighter's NAME: _____
SS #: _____ DATE OF BIRTH: _____
AGE: _____ Federal ID#_____CURRENT WEIGHT: _____ HEIGHT_____

TO BE COMPLETED BY EXAMINING PHYSICIAN:

UNLESS STATED Indicate normal findings by placing a check (VISION must be at least **20/70-W/O Glasses**)

1. Visual Acuity: **List Actual** _____ Peripheral Vision **(DEGREES)** _____

2. Pupils: Regular _____ Equal _____ React to light _____ Anterior Segment _____

3. Periorbital Regions (describe scars, if any) _____

4. Oropharynx: _____ Ears (discharge, etc.) _____

5. Lungs: (Any abnormal breath sounds, friction rub, rales, etc.) _____

6. Heart Rate: **List Actual** _____ Any irregularity _____ Murmurs _____

7. Pulse Rate: **List Actual** _____ Blood Pressure: **List Actual** _____

8. Abdominal Exam: _____

9. Extremities (Stiffness, swelling, tenderness): **YES** _____ **NO** _____

10. Hands (fists): Any Fractures, or Swelling: **YES** _____ **NO** _____

11. Nervous System: Orientation _____ Cerebellum _____ Cranial Nerves _____

12. Nose: Instability **YES** __ **NO** _____ Obstruction **YES** __ **NO** _____

13. Coordination: Finger to Nose - Normal _____ Abnormal _____

14. Tandem Gait: Normal _____ Abnormal _____

15. **In your opinion is this individual in condition to compete as a Pro/Amateur MMA/ Boxer: YES____ NO___**
IF NO WHY _____ _____

NAME OF EXAMINING PHYSICIAN (PRINT): _____
TELEPHONE #: _____ FAX #: _____
PHYSICIAN'S SIGNATURE: _____ DATE: _____

SEND TO:
PENNSYLVANIA STATE ATHLETIC COMMISSION
2525 N. 7TH Street
HARRISBURG, PA 17110

TELEPHONE #: 717-787-5720
FAX #: 717-783-0824