FIGHTERS: Please provide the requested information on the TOP HALF of this form.

Thank You

PHYSICIAN'S REPORT PRE-EVENT PHYSICAL EXAMINATION

FIGHTER FILLS THIS OUT

DATE___/___/____ TIME___:____ CITY________________ PROMOTER_________________

FIGHTER'S NAME:______________________________ LICENSE #:________________
(LAST) (FIRST)

ADDRESS:______________________ CITY:_____________ STATE:___ ZIP CODE:________

PHONE:HOME(____)___________ WORK(____)___________ DOB____/____/_____ SEX____

RECORD: WINS____ LOSSES____ DRAWS____ KO'S____ SS#______________________

DATE OF LAST FIGHT___/___/____ OPPONENT__________________ OUTCOME__________

PROMOTER___________________ CITY__________________ COUNTRY_________________

AGE_____ HEIGHT______ WEIGHT______ ALLERGIES_______________________________

MEDICATIONS____________________________

PRESENT ILLNESS/INJURY____

DOCTOR FILLS THIS OUT

EYES: LEFT__________ RIGHT__________ EARS: LEFT__________ RIGHT__________

HEAD___________ NOSE___________ THROAT___________ NEUROLOGICAL___________

CHEST_______________ CARDIOVASCULAR_______________ ABDOMEN_______________

MUSCULAR SKELETAL____________________ GENITO-URINARY______________________

PULSE_______ BLOOD PRESSURE____/___ REMARKS_______________________________

HEP B __________ HEP C _________ HIV ___________ PREGNANCEY ___________________

PERSONAL PHYSICIANS LETTER ___________________

CLEARED FOR CONTEST?: YES____ NO____ PHYSICIAN'S NAME_____________________

PHYSICIAN'S SIGNATURE_________________________ TYPE OF PRACTICE______________