MINNESOTA
OFFICE OF COMBATIVE SPORTS

PHYSICAL AND NEUROLOGICAL EXAMINATION

Only a licensed medical doctor or physician's assistant may conduct this examination and complete this form.

APPLICANT INFORMATION

Last name | First name | Middle name | Date of birth

PHYSICAL INFORMATION

Your **physician** must complete the remainder of this form in its entirety.

Height:_____ Weight:_____ Temp: _____ □ Afebrile RR:_____ BP: _____/_____ HR: _____

		Normal	Abnormal
General		□	□
HEENT	Head	□	□
	PERRLA/EOMI	□	□
	Periorbital regions	□	□
	Ears/hearing (grossly)	□	□
	Jaw/oropharynx/teeth	□	□
	Nose (stability, obstruction)	□	□
	Lymph nodes	□	□
	Neck	□	□
Vision	PERRLA/EOMI	□	□
	Peripheral/fields (grossly)	□	□
Heart	Rhythm/sounds/murmurs	□	□
Chest	Lungs	□	□
	Ribs	□	□

		Normal	Abnormal	Deferred
Abd.	(Hernias)	□	□	□
	(Masses/tenderness)	□	□	
Ext.	Extremities	□	□	
	Hands/wrists	□	□	
	Knuckle push-ups	□	□	
	Duck/crab walk	□	□	
Skin	(Rashes/lacerations)	□	□	
Neuro.	Alertness/orientation	□	□	
	Cranial nerves (grossly)	□	□	
	Tandem gait	□	□	
	Romberg/pronator drift	□	□	
	Finger to nose	□	□	
	Reflexes	□	□	
	Other: _____	□	□	

Abnormalities: _____

MEDICAL TESTING (All test results must be attached separately):

	Normal	Positive	Not reviewed	Date of test/exam
Hepatitis B surface antigen	□	□	□	_____/_____/_____
Hepatitis C antibody	□	□	□	_____/_____/_____
HIV antibody	□	□	□	_____/_____/_____
Other: _____	□	□	□	_____/_____/_____

I hereby certify that based on my physical findings, and pending any medical testing not yet reviewed, it is my opinion that said participant is in good physical condition and □ **IS** □ **IS NOT** medically cleared to be licensed as a competitor in professional boxing/mixed martial arts. *State reason if not cleared for competition below:*

_____

_____

_____ _____ _____ _____

Physician's name, M.D P.A. | Signature | License number | Date

_____ _____

Email | Phone