The Commonwealth of Massachusetts

Department of Public Safety
State Athletic Commission

Please submit application to:

One Ashburton Place, Room 1301, Boston, Massachusetts 02108

APPLICATION FOR FIGHTER'S LICENSE

(Please Type or Print Legibly)
(Illegible or incomplete applications will not be accepted)

Please check sport which you are seeking Licensure:

☐ BOXING ☐ MMA ☐ UNARMED COMBATANT: ____________________

☐ PROFESSIONAL ☐ AMATEUR

BACKGROUND INFORMATION

NAME ____
First Middle Initial Last

ADDRESS ____
Street City State Zip

DAYTIME TELEPHONE # (______)____________ SOCIAL SECURITY #________________________

DATE OF BIRTH _______/______/_______ PLACE OF BIRTH ________________________

E-MAIL ADDRESS ________________________ OCCUPATION ________________________

EMPLOYER'S NAME ____

EMPLOYER'S ADDRESS ____
Street City State Zip

EMPLOYER'S TELEPHONE # (______)________________________

HEIGHT ______________ PRESENT WEIGHT ______________

AMATEUR RECORD ________________ PROFESSIONAL RECORD ____________________

NAME AND ADDRESS OF TRAINER ____

DO YOU PRESENTLY SUFFER FROM ANY KNOWN MEDICAL CONDITION THAT WOULD MAKE IT UNSAFE FOR YOU TO ENGAGE IN AN UNARMED COMBATIVE SPORTING EVENT? ☐ YES ☐ NO

HAVE YOU EVER BEEN HOSPITALIZED DUE TO AN UNARMED COMBAT RELATED INJURY? IF YES, PLEASE ATTACH A WRITTEN EXPLANATION. ☐ YES ☐ NO

THE FOLLOWING ITEMS MUST ACCOMPANY THIS APPLICATION
(check box indicating compliance):

- ☐ $75 application fee for professional fighters (no fee for amateur fighters until further notice)
- ☐ Two passport photographs (2" x 2" in size) of the applicant's head (without headwear) **FOR NON-RESIDENTS**
- ☐ Copy of a government issued photo identification (e.g.- driver's license)
- ☐ Copy of birth certificate
- ☐ Record of Medical Examination form
- ☐ (For Professional and Amateur fighters who have never been licensed in Massachusetts) Debut Form

AUTHORIZATION FOR RELEASE OF RMV INFORMATION – FOR MA RESIDENTS

My signature below authorizes the Department of Public Safety to electronically access my photograph from the Massachusetts Registry of Motor Vehicles database solely for use on this license/registration.

____
MA- RMV photo release signature

[ ] (OPTIONAL)
\Please check here if English is not your primary language AND your ability to read, write, speak, or understand English is limited. If you checked the box, please indicate what your primary language is:

Arabic	Chinese	French	German	Italian	Korean	Polish
Portuguese	Russian	Spanish	Tagalog	Vietnamese	Other____________	

ATTESTATION

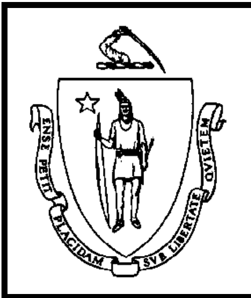
I hereby attest, under the pains and penalties of perjury, that the information provided above is true and accurate to the best of my knowledge. Further, I certify that I have filed all required tax returns and paid all state taxes as required by law.

____________________________ ____________________
Signature of applicant Date

FOR COMMISSION USE ONLY

DATE OF COMMISSION REVIEW: ________________
APPROVED _____ DENIED ______
DATE LICENSE MAILED: ____________________
REASON FOR DENIAL:

Rev. 4/11



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RECORD OF MEDICAL EXAMINATION
(MUST BE COMPLETED WITHIN THIRTY DAYS OF SUBMISSION OF APPLICATION FOR LICENSURE)

BACKGROUND

FIGHTER'S NAME: ______________________ FIGHTER'S D/O/B: ____________

DATE OF EXAMINATION: ____________ HEIGHT: ____________ WEIGHT: ____________

NAME OF EXAMINING PHYSICIAN: ______________________

ADDRESS OF PHYSICIAN: ______________________

TELEPHONE # OF PHYSICIAN: ______________________

STATE IN WHICH PHYSICIAN IS LICENSED TO PRACTICE MEDICINE: ______________________

INSTRUCTIONS

All applicants for licensure as an unarmed combatant in Massachusetts must undergo a complete physical examination, including neurological and cardiac testing, by a licensed physician. The examination must include a review by the physician of the medical records identified below. Applicants should be in excellent health at the time of the examination in order for the examining physician to approve of licensing the individual. This form must be completed by the examining physician and given to the applicant so that it may be submitted to the Commission along with their application for licensure as an unarmed combatant. The physical examination and corresponding review of medical documentation may not take place more than thirty days prior to the submission of an application.

MEDICAL HISTORY

Has this individual ever suffered a concussion? ☐ YES ☐ NO

If yes, please provide date(s) and circumstances: ______________________

____

____

Does this individual wear contact lenses? ☐ YES ☐ NO

Has this individual undergone LASIK eye surgery? ☐ YES ☐ NO
(If yes, clearance to fight must be obtained from an optometrist or ophthalmologist prior to licensure.)

Please identify any present medical issues or past conditions you believe the Commission should be aware of in determining whether to license this individual as a professional combatant:

____

____

____

REVIEW OF MEDICAL RECORDS

The examining physician must review the records identified below and check the box indicating that the review has been performed. Please ensure that the examinations were performed within **30 days** of the review. The reviewing physician must be left satisfied that the records are authentic. The reviewed medical records must be attached to this form and submitted to the Commission.

☐ RECORD OF PHYSICAL EXAMINATION PERFORMED IN CONJUNCTION WITH THIS REVIEW

☐ EVIDENCE OF AN ASYMPTOMATIC ELECTROCARDIOGRAM (EKG) WITHIN **30 DAYS** PRECEDING THE DATE OF THE EXAMINATION

☐ EVIDENCE OF A NEGATIVE TEST FOR HIV, HEPATITIS BsAG, AND HEPATITIS CAB WITHIN **30 DAYS** PRECEDING THE DATE OF THE EXAMINATION

☐ EVIDENCE OF AN ASYMPTOMATIC DILATED EYE EXAMINATION BY AN OPTOMETRIST OR OPHTHALMOLOGIST WITHIN **30 DAYS** PRECEDING THE DATE OF THE EXAMINATION

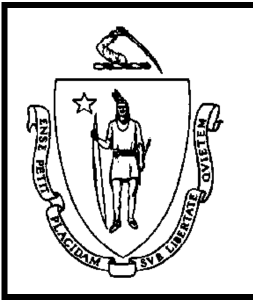
☐ (IF APPLICABLE) (NOT REQUIRED FOR INDIVIDUALS APPLYING FOR AN AMATEUR LICENSE) EVIDENCE OF AN ASYMPTOMATIC BRAIN CT, BRAIN MRI, OR NEUROLOGICAL EXAMINATION PERFORMED BY A NEUROLOGIST OR NEUROSURGEON WITHIN **5 YEARS** PRECEDING THE DATE OF EXAMINATION (INDIVIDUALS 35 YEARS OF AGE AND OLDER ARE REQUIRED)

PHYSICIAN ATTESTATION

I hereby attest that I have examined the above named individual and reviewed all of the medical records identified above. I am aware that this individual seeks to be licensed as an unarmed combatant. In my medical opinion this individual does not suffer from any known conditions which should prevent them from competing and is otherwise presently fit to be licensed as an unarmed combatant.

______________________ ______________________ ____________

NAME OF PHYSICIAN (PRINT) SIGNATURE OF PHYSICIAN DATE



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DEBUT IN MASSACHUSETTS FORM

BIOGRAPHICAL INFORMATION

NAME OF FIGHTER: ______________________________

DATE OF BIRTH: ____________________ SOCIAL SECURITY #: ______________________________

HEIGHT: ________________ PRESENT WEIGHT: __________________

AMATEUR RECORD: ___________________ PROFESSIONAL RECORD: ___________________

NAME AND ADDRESS OF TRAINER: ______________________________

____

(FOR MMA FIGHTERS) TEAM: ______________________________

NAME AND ADDRESS OF MANAGER (IF ANY): ______________________________

____

SPORT FOR WHICH YOU ARE SEEKING LICENSURE: ☐ BOXING ☐ MMA ☐ UNARMED COMBATANT

DISCIPLINE: ______________________________

EXPERIENCE

AMATEUR RECORD: _____________________ ☐ ATTACH RESULTS LIST OF ALL AMATEUR FIGHTS

PROFESSIONAL RECORD: _______________________ ☐ ATTACH RESULTS LIST OF ALL PRO FIGHTS

-OTHER STATES IN WHICH YOU HAVE BEEN LICENSED: ______________________________

____

LENGTH OF TRAINING PERIOD FOR PRESENT MATCH: ______________________

ATTESTATION

TWO INDIVIDUALS WITH PERSONAL KNOWLEDGE MUST ATTEST AS TO THE FITNESS OF THE FIGHTERTO PARTICIPATE IN A MATCH BY COMPLETING THE SECTION BELOW. ONE OF THESE INDIVIDUALS MUST BE THE FIGHTER'S TRAINER.

1. I, ________________________, HEREBY SWEAR OR ATTEST UNDER THE PAINS AND PENALTIES OF PERJURY THAT IN MY OPINION THE ABOVE NAMED FIGHTER HAS THE NECESSARY SKILLS AND IS OTHERWISE FIT TO COMPETE IN A PROFESSIONAL ________________________________ MATCH.
(INSERT SPORT)

-RELATIONSHIP TO FIGHTER: **TRAINER**
-MA TRAINER'S LICENSE#: ____________________________
-LENGTH OF TIME KNOWN FIGHTER: ___________________
-PHONE #: (______) _________________________ -EMAIL: ________________________________
-ADDRESS: ____

________________________________ ____________________
SIGNATURE DATE

2. I, ________________________, HEREBY SWEAR OR ATTEST UNDER THE PAINS AND PENALTIES OF PERJURY THAT IN MY OPINION THE ABOVE NAMED FIGHTER HAS THE NECESSARY SKILLS AND IS OTHERWISE FIT TO COMPETE IN A PROFESSIONAL ________________________________ MATCH.
(INSERT SPORT)

-RELATIONSHIP TO FIGHTER: ___________________________
-MA TRAINER'S LICENSE#: ____________________________
-LENGTH OF TIME KNOWN FIGHTER: ___________________
-PHONE #: (______) _________________________ -EMAIL: ________________________________
-ADDRESS: ____

________________________________ ____________________
SIGNATURE DATE