TEXAS DEPARTMENT OF LICENSING & REGULATION

P.O. Box 12157 • Austin, Texas 78711-2157
www.tdlr.texas.gov

COMBATIVE SPORTS PROFESSIONAL CONTESTANT LICENSE APPLICATION INSTRUCTIONS

1. NAME – Provide your legal name in the spaces provided. (Last, First, Middle Name, Suffix) Examples of a suffix include Jr., Sr., and (Mr. is not a suffix.)
2. DATE OF BIRTH – Provide your birth date. Minors age 17 but not yet 18 may be issued a contestant's license with a notarized written consent from a parent or guardian.
3. PLACE OF BIRTH – Provide the city, state, and country of your place of birth.
4. GENDER - Select whether you are male or female.
5. SOCIAL SECURITY NUMBER – Social security number disclosure is required by Section 231.302(c)(1) of the Texas Family Code in order to obtain a license. Your social security number is subject to disclosure to an agency authorized to assist in the collection of child support payments, contact the ***Texas Attorney General***.
6. FOREIGN NATIONAL PASSPORT NUMBER – Applicants who are foreign nationals, must provide their passport number.
7. MAILING ADDRESS – Provide your current mailing address. This is the address where we will send you mail. This address can be a post office box. Add the zip plus-4 to help the postal service deliver mail more efficiently and accurately.
8. EMAIL ADDRESS – Provide your email address. By providing my email address I authorize TDLR to send licensing communications and required notices to me by electronic mail. I understand that I may revoke this authorization in writing and that I must update my email address, or I will not receive these notices. I understand that the email address I have provided in this application will remain confidential except as permitted or required by law.
9. PHONE NUMBER – Provide a telephone number, including the area code, where we can reach you during the day. This may be your office phone number where we can leave a message.
10. EVENT DATE – Provide the date of the combative sports event you are participating in.
11. PROMOTER NAME – Provide the name of the promoter of the combative sports event.
12. STATEMENT OF APPLICANT – Carefully read the statement before you sign and date your application.
13. AUTHORIZATION TO RELEASE MEDICAL RECORDS – Carefully read the consent to release medical records before you sign and date the release.
14. PROFESSIONAL CONTESTANT'S MEDICAL EXAMINATION – Parts 1 must be completed by the contestant. Part 2 must be completed by a medical doctor licensed by a state, district, or territory of the United States of America. Part 2 signed by a physician's assistant or nurse practitioner will not be accepted. A contestant's medical examination records are only valid for six months from the date of completion.
15. OPHTHALMOLOGIC MEDICAL EXAMINATION – This exam must be completed by an ophthalmologist or optometrist licensed by a state, district, or territory of the United States of America. Ophthalmologic medical examination records are only valid for six months from the date of completion.

APPLICATION INFORMATION FOR MILITARY SERVICE MEMBERS, MILITARY VETERANS, AND MILITARY SPOUSES:

The Texas Department of Licensing and Regulation recognizes the contributions of our active duty military service members, their spouses, and veterans. If you want to use one of the licensing options available to military service members, military veterans and military spouses, please complete the ***Military Service Member, Military Veteran or Military Spouse Supplemental Application (PDF)*** and attach it with your license application. If you have additional questions about qualifications, training or experience requirements relating to occupation licensing for military service members, military veterans or military spouses please go to ***TDLR Military Information.***

SEND YOUR COMPLETED APPLICATION AND REQUIRED DOCUMENTS TO:

Texas Department of Licensing and Regulation
P.O. Box 12157
Austin, TX 78711-2157

Documents submitted with your application will not be returned. Keep a copy of your completed application, all attachments, and your check or money order. Do not send cash.

For additional information and questions, visit the ***TDLR website*** or reach Customer Service via ***webform***. The webform will allow you to submit your request for assistance and include attachments needed. Customer Service Representatives are available Monday through Friday (excluding holidays) at (800) 803-9202 (in state only), (512) 463-6599, or Relay Texas-TDD: (800)735-2989.

TDLR PUBLIC INFORMATION ACT POLICY:

This document is subject to the Texas Public Information Act. With certain exceptions, information in this document may be made available to the public. For more information, view the ***TDLR Public Information Act Policy***.

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COMBATIVE SPORTS PROFESSIONAL CONTESTANT LICENSE APPLICATION

YOU MUST MEET ALL REQUIREMENTS WITHIN 12 MONTHS OF THE FILING DATE, OR THE APPLICATION WILL BE TERMINATED.

APPLICATION FEE: $20 (FEE IS NON-REFUNDABLE)

1. Name:

Last ____ First ____ Middle Name ____ Suffix (SR, JR, III) ____

2. Date of Birth: ____ mm/dd/yyyy

3. Place of Birth: (City, State, and Country) ____

4. Gender: ☐ **Male** ☐ **Female**

5. Social Security Number:
(See instruction sheet for disclosure information) ____

6. Foreign National Passport Number: (Foreign nationals must provide their passport number) ____

7. Mailing Address: (A PO box is allowed for this address)

Number, Street Name, Suite Number/Apartment Number ____

City ____ State ____ Zip Code ____

8. Email Address: ____

(Ex: johndoe gmail.com) See instruction sheet for disclosure information

9. Phone Number: ____ Phone Number

10. Event Date: ____ mm/dd/yyyy

11. Promoter Name: ____

12. STATEMENT OF APPLICANT

I certify that I have read and will comply with all applicable laws and rules of the Combative Sports Program including Texas Occupations Code, Chapter 51 and Chapter 2052 (Combative Sports Act) and the Combative Sports Administrative Rules under 16 Texas Administrative Code, Chapter 60 and Chapter 61.

I understand that providing false information on this application may result in denial of this application and/or revocation of the license I am requesting and the imposition of administrative penalties.

Applicant Signature ____ Date Signed ____

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Please read this entire form before signing and complete all sections.

1. I authorize the Texas Department of Licensing and Regulation to use and disclose my protected health information/medical records to the appropriate governmental authorities or myself with respect to my status as a licensed contestant.

2. This authorization for release of information covers all past, present, and future medical records.

3. I authorize the release of <u>all</u> protected health information/medical records submitted to TDLR as a part of the following:

   - Professional Contestant's Medical Examination - Part 1
   - Professional Contestant's Medical Examination - Part 2
   - Ophthalmologic Medical Exam

4. I understand that the authorization to release **all** of the above-referenced protected health information/records **includes** the release of information/records relating to communicable diseases, *Human Immunodeficiency Virus* (**HIV**) or Acquired Immune Deficiency Syndrome (**AIDS**).

5. This authorization shall remain in effect until the expiration of my license, at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I have read this form and agree to the uses and disclosure of the health information/medical records as described.

I understand that refusing to sign this form does not affect disclosures of health information/medical records that have occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission.

I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy law.

PRINT NAME OF APPLICANT ______________________________

SIGNATURE OF APPLICANT ______________________________

DATE SIGNED ________________

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PROFESSIONAL CONTESTANT'S MEDICAL EXAMINATION - PART 1

Last Name ______________ ______________ ______________ Federal/National ID: ______________
Last First Middle

Address: ______________ ______________ ______________ ______________
Street Number, Street Name City State County

Telephone: ______________ E-mail: ______________ Date of Birth: ______________

Sex: □ M □ F Emergency Contact: ______________ Emergency Telephone: ______________

ALL SECTIONS MUST BE ANSWERED

Health History
Do you have or have you ever had any of the following?

	Yes	No
Seizure, flashing lights	☐	☐
Headaches or dizziness	☐	☐
Cerebral hemorrhage	☐	☐
Passed out during exercise	☐	☐
Double or blurred vision	☐	☐
LASIK, PRK, or other eye surgery	☐	☐
Retinal Detachment	☐	☐
Hearing difficulty	☐	☐
Broken nose	☐	☐
Chest pain	☐	☐
Irregular heart beat or murmur Muscle	☐	☐
cramping during exercise	☐	☐

	Yes	No
High blood pressure	☐	☐
Asthma or wheezing	☐	☐
Broken bones or recent sprains	☐	☐
Neck or spine injury	☐	☐
Hernia	☐	☐
Cold sores, fever blisters or herpes	☐	☐
Diabetes	☐	☐
Bleeding problems	☐	☐
Hepatitis or liver problems	☐	☐
Heat stroke/heat exhaustion	☐	☐
Recent illness or fever	☐	☐
Sickle cell trait or disease	☐	☐

If "Yes" to any of the above, explain: ______________

Results of the following blood tests MUST be attached to the application:
☐ **Hepatitis B Surface ANTIGEN** ☐ **Hepatitis C ANTIBODY** ☐ **HIV ANTIBODY**

	Yes	No
Have you ever had a concussion, a head injury, or lost consciousness?	☐	☐
Do you or have you ever used steroids, testosterone, or banned	☐	☐
substances? Have you ever had any other surgeries?	☐	☐
Do any diseases run in your family?	☐	☐
Have you seen a doctor for *any* medical problem in the last 3 months?	☐	☐
Do you have any other medical conditions or training/sparring injuries?	☐	☐
Women only: Have you ever had any type of breast surgery?	☐	☐
Are you allergic to any medications or supplements?		

What medications or supplements are you taking on a regular basis? ______________

What medications or supplements have you taken within the last two weeks? ______________
____

Sport History
Amateur Record: ______________ ______________

Date of last bout: ______________ Result: ______________ Number of times knocked out: ______________

Number of times knocked out in past year: ______________ Date of last knock out: ______________

A PERSON 36 YEARS OF AGE OR OLDER MUST SUBMIT A FAVORABLE
□ EEG (Electroencephalography) AND □ EKG (electrocardiogram)

I understand that the examining physician depends on the reliability of the statements I made above I attest that the answers given above are true and correct to the best of my knowledge and belief.

______________ ______________ ______________
Contestant Applicant Name (printed) Signature Date

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PROFESSIONAL CONTESTANT'S MEDICAL EXAMINATION - PART 2

This form MUST be completed by a LICENSED PHYSICIAN (M.D./D.O.).

Last Name ________ (Last) ________ (First) ________ (Middle) Federal/National ID: ________

Address: ________ (Street Number, Street Name) ________ (City) ________ (State) ________ (County)

Telephone: ________ E-mail: ________ Date of Birth: ________

Sex: □ M □ F Emergency Contact: ________ Emergency Telephone: ________

ALL SECTIONS MUST BE ANSWERED

PHYSICAL EXAM: This section is to be completed by the examining physician.

□ **The athlete presented a valid form of photo identification and I have personally verified his/her identity.**

Height:_______ Weight:_______ Temp:_____ 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
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: ________	□	□

Abnormals: ____

____

I hereby certify that based on the statements made by the contestant applicant on the reverse side of this form, my physical findings, and pending any medical testing not yet reviewed, it is my opinion that contestant applicant □ **IS** □ **IS NOT** in good physical condition and □ **IS** □ **IS NOT** medically cleared to be licensed as a contestant in a professional boxing/mixed martial arts event.

Reason if NOT cleared for competition: ____

________ Physician's Name, M.D./D.O. ________ Signature ________ License No. ________ Date

________ Office Address ________ Phone ________ Fax

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OPHTHALMOLOGIC MEDICAL EXAMINATION

This form must be completed by a LICENSED OPHTHALMOLOGIST or OPTOMETRIST

Legal Name: ______________________ ______________________ ______________________
Last First Middle

Date of Birth: ______________________
mm/dd/yyyy

ALL SECTIONS MUST BE ANSWERED

Visual Acuity Measurement	**RIGHT EYE**	**LEFT EYE**	**Normal**	**Abnormal**
Without Correction	N ____/____	N ____/____	☐	☐
	F ____/____	F ____/____	☐	☐
With Correction	N ____/____	N ____/____	☐	☐
	F ____/____	F ____/____	☐	☐
Tonometry Measurements	_____ mmHg	_____ mmHg	☐	☐
Exterior Exam			☐	☐
Anterior Exam			☐	☐
Fundi			☐	☐
Extraocular Muscles			☐	☐
Visual Fields (confrontation)			☐	☐

Explain Abnormal Findings: ____

____

Diagnosis: ____

____

Dilated exam was performed on ______________________ **Date of exam:** ______________________
Applicant Contestant Name mm/dd/yyyy

I APPROVED THIS PERSON TO PARTICIPATE IN A COMBATIVE SPORTS EVENT

Ophthalmologist or Optometrist Name (print) ______________________ ______________________
License Number

Street Address ______________________ City ______________________ ______________________
State

______________________ ______ ______________________
Zip Code Phone Number

Ophthalmologist or Optometrist Signature ______________________ Date ______________________

Contestant Applicant Name ______________________ ______________________ ______________________
(printed) Signature Date