



# TEXAS DEPARTMENT OF LICENSING & REGULATION

P.O. Box 12157 • Austin, Texas 78711-2157

(512) 539-5722 • FAX (512) 463-1087

[www.tdlr.texas.gov](http://www.tdlr.texas.gov) • [combative.sports@tdlr.texas.gov](mailto:combative.sports@tdlr.texas.gov)

## AMATEUR COMBATIVE SPORTS CONTESTANT REGISTRATION (Including Physical Exam & Eye Exam)

**Submit all medical exams and test results with this registration form.**

Full Legal Name:

First, Middle, Last

Gender:

Male

Female

Mailing Address:

Street Number, Street Name, Apt. or Ste. #, City, State, Zip

Telephone #:

Date of Birth:

Social Security #

Place of Birth:

(Foreign Nationals may submit Passport #)

(City & State or Country is not U.S. Citizen)

Email Address:

Association Name:

Event Date:

### Amateur Affidavit

I certify, under penalty of perjury, that I have not participated in any Combative Sports Event for profit or as a professional.

By signing this registration form, I certify that all information is true and correct. I understand that providing false information on this form may result in sanctions up to and including denial or revocation of the registration.

\_\_\_\_\_  
Contestant Signature

\_\_\_\_\_  
Date



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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 all protected health information medical records submitted to TDLR as a part of the following
  - Amateur Contestant's Medical Examination - Part 1
  - Amateur 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.

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

Contestant Name (Please Print): \_\_\_\_\_

## AMATEUR CONTESTANT'S MEDICAL EXAMINATION – PART 1

**TO BE COMPLETED BY A LICENSED MEDICAL DOCTOR ONLY**

**Forms completed by a physician assistant or nurse practitioner will NOT be accepted.**

Medical Allergies: \_\_\_\_\_

Medications?    YES        NO    Explain: \_\_\_\_\_

Previous Hospitalization(s) or Surgery (include dates): \_\_\_\_\_

**The following blood tests must be attached to this application:**  
Hepatitis B surface ANTIGEN  
Hepatitis C ANTIBODY  
HIV ANTIBODY

**Contestants 36 and over must also provide a favorable:**  
EEG (Electroencephalography) and  
EKG (Electrocardiogram)

**ALL MEDICAL AND LAB TEST RESULTS MUST BE DATED, SIGNED AND TAKEN NO MORE THAN 6 MONTHS BEFORE THE REGISTRATION IS SUBMITTED.**

**Health History:**

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

	YES	NO		YES	NO
Bleeding Tendencies			Seizures and Convulsions		
Diabetes			Asthma		
Hernia			High Blood Pressure		
Heart Disease			Tuberculosis		
Sickle Cell Disease			Mononucleosis		
Kidney Disease			Cough		
Hepatitis			Psychiatric Problems		
Skin Disease			Contact Lenses		
Headaches			Number of Times KO'D		
Joint Injury or Dislocation			Kidney/Lung/Testicle/Eye Removed		
Concussion/Unconsciousness			(circle all that apply)		

If 'YES' to any of the above, explain: \_\_\_\_\_  
\_\_\_\_\_

Do you have any other information concerning the contestant's health, past or present, which is NOT COVERED by the questions above? If so, describe: \_\_\_\_\_

**EXAMINING MD or DO NAME (Please print)** \_\_\_\_\_

**MEDICAL LICENSE #** \_\_\_\_\_ **Phone** \_\_\_\_\_  
(Must be licensed in a State, District or Territory of the United States)

**ADDRESS** \_\_\_\_\_  
(Street Number, Street Name, Suite Number, City State, Zip Code)

**MD or DO SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**CONTESTANT SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_



Contestant Name (Please Print): \_\_\_\_\_

**\*\* OPHTHALMOLOGIC MEDICAL EXAM \*\***

**Exam with dilation must be done by an Ophthalmologist or Optometrist.**

Examination (Normal = N; Abnormal = X)	Right Eye	Left Eye	Normal	Abnormal
Visual Acuity (without correction)	F /	F /		
	N /	N /		
Visual Acuity (with correction)	F /	F /		
	N /	N /		
Exterior Exam				
Anterior Exam				
Fundi				
Extraocular Muscles				
Visual Fields				
Tonometry				

Explain abnormal findings:

Diagnosis:

I hereby certify that I examined \_\_\_\_\_ on \_\_\_\_\_.  
(Please print contestant's name) (date)

**I HAVE APPROVED THIS PERSON TO PARTICIPATE IN A COMBATIVE SPORTS EVENT.**

Name of Ophthalmologist or Optometrist \_\_\_\_\_  
(Please print)

LICENSE # \_\_\_\_\_ Phone \_\_\_\_\_  
(Must be licensed in a State, District or Territory of the United States)

ADDRESS \_\_\_\_\_  
(street number, street name, suite number, city, state, zip code)

OPHTHAMOLOGIST or  
OPTOMETRIST SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

CONTESTANT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_