



# THE COMMONWEALTH OF MASSACHUSETTS

DIVISION OF PROFESSIONAL LICENSURE

STATE ATHLETIC COMMISSION

1 FEDERAL STREET, SUITE 0600

BOSTON, MA 02110-2012

## Application Instructions for Professional Fighter's License

To be licensed as a professional unarmed combatant/fighter, you must submit the following to this office.

- Completed Application
- \$25 Non-refundable Application Fee made payable to the Commonwealth of Massachusetts (A Fighter's License is Valid for One Day Only)
- \$10.00 Federal ID fee made payable to the Commonwealth of Massachusetts, if applicable
- Non-Massachusetts Residents Only: One Passport Photo (2" x 2") of Applicant
- Copy of a Government Issued Photo Identification (e.g. Driver's License/Passport)
- Medical Information

\* Physical examination to determine whether the unarmed combatant is physically fit to compete performed by a licensed physician within 1 year of the event

\* An electrocardiogram (EKG) within 1 year of the event for which a first license is sought, then within 5 years thereafter

\* Blood test results for HIV, Hepatitis BsAG and Hepatitis Cab

\* A dilated eye exam by an optometrist or ophthalmologist within 1 year of the event

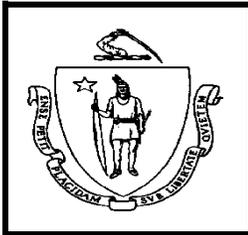
\* A brain CT or brain MRI within 5 years of the event

\* No earlier than 1 day prior to the event, all female fighters must provide satisfactory proof to a Commission approved physician that they are not pregnant

**NOTE: The record of each test/examination must include an acknowledgement from the examining physician that the applicant is "physically fit to compete" or "cleared to fight."**

### MEDICAL RECORDS FROM OTHER STATES/JURISDICTIONS

The Massachusetts State Athletic Commission (MSAC) accepts records of medical examinations from other states/jurisdictions as long as they comply with MSAC regulations. MSAC will also share your medical information with other states/jurisdictions as long as you complete a written authorization granting MSAC permission to release your medical information.



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## APPLICATION FOR PROFESSIONAL FIGHTER'S LICENSE

Please check sport which you are seeking Licensure:

BOXING

MMA

MUAY THAI (SOUTHEAST ASIAN KICKBOXING)

**NON-REFUNDABLE APPLICATION FEE: \$25 (CHECK OR MONEY ORDER ONLY)**

### APPLICANT INFORMATION

NAME \_\_\_\_\_  
First Middle Initial Last

ADDRESS \_\_\_\_\_  
Street City State Zip

DAYTIME TELEPHONE # (\_\_\_\_\_) \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

*FOREIGN NATIONALS ONLY:* PASSPORT # \_\_\_\_\_

DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ PLACE OF BIRTH \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_ OCCUPATION \_\_\_\_\_

EMERGENCY CONTACT NAME & NUMBER \_\_\_\_\_

### COMBAT INFORMATION

HEIGHT \_\_\_\_\_ PRESENT WEIGHT \_\_\_\_\_

WHAT WAS YOUR AMATEUR RECORD? WINS \_\_\_\_\_ LOSSES \_\_\_\_\_ DRAWS \_\_\_\_\_

WHAT IS YOUR PROFESSIONAL RECORD? WINS \_\_\_\_\_ LOSSES \_\_\_\_\_ DRAWS \_\_\_\_\_

ARE YOU CURRENTLY LICENSED BY ANY OTHER ATHLETIC COMMISSION? \_\_\_\_\_

IF YES, WHERE? \_\_\_\_\_

HAVE YOU EVER BEEN SUSPENDED/DISCIPLINED BY ANY OTHER ATHLETIC COMMISSION? \_\_\_\_\_

IF YES, PLEASE EXPLAIN. \_\_\_\_\_

DO YOU PRESENTLY SUFFER FROM ANY KNOWN MEDICAL CONDITION THAT WOULD MAKE IT UNSAFE FOR YOU TO ENGAGE IN AN UNARMED COMBATIVE SPORTING EVENT? \_\_\_\_\_

IF YES, PLEASE EXPLAIN. \_\_\_\_\_

HAVE YOU EVER BEEN HOSPITALIZED DUE TO AN UNARMED COMBAT RELATED INJURY? \_\_\_\_\_

IF YES, PLEASE EXPLAIN. \_\_\_\_\_

HAVE YOU EVER BEEN CONVICTED OF A CRIME BY ANY STATE OR JURISDICTION? \_\_\_\_\_

IF YES, PLEASE EXPLAIN. \_\_\_\_\_

EXPLAIN YOUR CURRENT TRAINING REGIMEN. \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF RMV INFORMATION – FOR MA RESIDENTS ONLY**

My signature below authorizes the State Athletic Commission 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

\_\_\_\_\_  
Date

**FIGHTER 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 \_\_\_\_\_

REASON FOR DENIAL: \_\_\_\_\_

**VOLUNTARY AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

I \_\_\_\_\_ hereby authorize the Massachusetts State Athletic Commission (MSAC) to release/disclose/share my medical and personal information with respect to my status and licensure as an unarmed combatant to other state or tribal athletic commissions. This information, which is required pursuant to 523 CMR 6.02, includes but is not limited to my physical examinations/reports, blood test results (HIV, Hepatitis B/C), MRI/CT scans and ophthalmological examinations/reports. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient, and if so, may not be subject to federal or state law protecting its confidentiality.

This authorization shall remain in effect for five years from the date it is signed. I understand that I may cancel/revoke this authorization at any time by sending written notification to MSAC. The cancellation/revocation will not apply to any information already released while the authorization was in effect.

This authorization is intended to satisfy the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Massachusetts Fair Information Practices Act (FIPA) pursuant to M.G.L c. 66A and any other applicable statutes and regulations.

I hereby release MSAC from any and all claims and liabilities that may arise out of the disclosure of my medical and personal information pursuant to this authorization.

I understand that this authorization is voluntary. My eligibility to participate in unarmed combat will not be affected by my refusal to sign this authorization.

\_\_\_\_\_  
Printed Name of Applicant

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date