# Combat Sports Authority of Maine

# Fighters Packet

(Includes forms needed for Licensing, Medicals, etc...)

P.O. Box 10525
Portland, ME 04104
(207) 712-6615
fax(207)482-0965

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# FIGHTERS CHECKLIST

*** PLEASE USE CSAM FORMS ***

*** Visit www.mainecombatsports.com for forms ***

1) Complete Competitors License App if needed
   *** Return to CSAM via email or FAX – 207-482-0965
2) Have your Corners, Seconds, Trainers, Managers fill out regular License Application
   *** Return to CSAM via email or FAX – 207-482-0965
3) Complete National ID App. (If you do not already have a National ID card)
   *** Return to CSAM via email or FAX – 207-482-0965
4) Complete Corners Form (by weigh-ins)
5) Complete Physical Exam Report (Dr. must check off the he/she cleared you to fight)***
   *** return to Promoter before Weigh-ins
6) Eye Exam Results (must be with Dilated Pupil Exam) ***
   *** return to Promoter before Weigh-ins
7) Blood Work Results**
   a. HIV Exam ** (Must be negative)
   b. Hepatitis B Exam **
      i. Hepatitis B Surface Antigen Test (HBsAg) must be negative
   c. Hepatitis C Exam **
      i. Anti HCV Test Must be negative

   *** return to Promoter before Weigh-ins
8) Woman - Negative Pregnancy Test (administered at weigh-ins)

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** Copy of the actual Lab Report for blood work must be provided. No other documentation will be accepted. Blood must have been tested within the past 180 days. No exceptions will be made.
***Within the past 12 months

# Competitors License Application

## Combat Sports Authority of Maine

P.O. Box 10525
Portland, ME 04104
Ph(207) 712-6615
Fax(207) 482-0965
combatsportsmaine@yahoo.com

| Office Use: |
|---|
| License Number: |
| New ☐ Renewal ☐ |
| Expires: |
| Receipt Number: |

**(Please email CSAM a digital headshot)** **FEE: $30** ☐ **Professional** ☐ **Amateur**

**Section One:** (Please print legibly)

| Name: (last First Middle Init) | | | | Soc Sec Nbr (last 4) XXXX-XX- | | Email Address |
|---|---|---|---|---|---|---|
| Address (Number & Street) | | City | | State | Zip | Phone: (Home) |
| DOB: (mm/dd/yy) | Age | Sex | Cage Name | | | Phone: (Cell) |

| | |
|---|---|
| Have you ever been convicted of a crime other than traffic offenses: Yes ☐ No ☐ | If yes, state type and where crime was committed: |
| Have you ever been suspended or penalized by any other state of commission? Yes ☐ No ☐ | If yes, state Commission, and what action was taken. |
| Have you ever had a license in another state? Yes ☐ No ☐ | If yes, state where. |

**Section Two: Medical Information**

| | | |
|---|---|---|
| Date of last complete medical exam standards: other than pre-fight: / / | What state was exam taken: | Does this state meet Maine standards? ☐ Yes ☐ No ☐ Unknown |
| Have you ever had a brain CAT Scan or MRI exam? ☐ Yes ☐ No If yes, date: / / | Height: Weight: Hair Color: Eye Color: | |

**POLICY FOR OUT OF STATE FIGHTERS:**

1) The burden is on the fighter to establish that when using any other state physical exam, that those requirements are as stringent as those required by the State of Maine.
2) The fee is the same as required for a Maine license.

I hereby verify that the information on this license application is TRUE. I further agree that the Combat Sports Authority of Maine may use any film, photograph, or other material in which I appear as the Authority deems appropriate.

| Applicants Signature (Must be signed for license to become valid) | Date: / / | Make checks payable to: Combat Sports Authority of Maine |
|---|---|---|

# License Application

## Combat Sports Authority of Maine

P.O. Box 10525
Portland, ME 04104
(207) 712-6615 fax(207)482-0965

| Office Use: |
|---|
| License Number: |
| New ☐ Renewal ☐ |
| Expires: |
| Receipt Number: |

**Check License being applied for: ($30)**

Judge ☐ Referee ☐ Timekeeper ☐ Physician ☐ Promoter ☐
Match Maker ☐ Manager ☐ Trainer ☐ Second ☐ Corner ☐

**Section One:** (Please print legibly)

| Name: (last First Middle Init) | | | | Soc Sec Nbr (last 4) XXX-XX- | | Email Address |
|---|---|---|---|---|---|---|
| Address (Number & Street) | City | | | State | Zip | Phone: (Home) |
| DOB: (mm/dd/yy) | Age | Sex | Language other than English | | | Phone: (Cell) |

| Have you ever been convicted of a crime other than traffic offenses: Yes ☐ No ☐ | If yes, state type and where crime was committed: |
|---|---|
| Have you ever been suspended or penalized by any other state of commission? Yes ☐ No ☐ | If yes, state Commission, and what action was taken. |
| Have you ever had a license in another State? Yes ☐ No ☐ | What State? |

**Section Two: For Promoters** (please list reference who can verify financial responsibility)

| Financial Institution | Address: (Number & street) | City | State | Zip |
|---|---|---|---|---|
| Contact Person | Title | Phone | | |

**Section Three: For Physicians**

| Physician number: | Please check which medical profession applies: Medical ☐ Doctor of Osteopathic medicir ☐ | Years of practice: |
|---|---|---|

**References:** (Please list two references)

| Name: | Address: (Number & Street) | City | State | Zip | Phone |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

**I hereby verify that the information on this license application is TRUE. I further acknowledge if I am licensing as an official, I am an independent contractor and I am not entitled to any benefits provided to State employees. I further agree that the Combat Sports Authority of Maine may use any film, photograph, or other material in which I appear as the Authority deems appropriate.**

| Applicants Signature (Must be signed for license to become valid) | Date: / / | Make checks payable to: Combat Sports Authority of Maine |
|---|---|---|

# Physical Examination Report

## Combat Sports Authority of Maine

P.O. Box 10525
Portland, ME 04104
(207) 712-6615 fax(207)482-0965

Name _____ Date of birth _____ Phone Number _____

Address (street) _____ City _____ State _____ Zip _____

**Contestant's Medical History:** (Has the applicant ever had any of the following conditions)

☐ Fainting spells ☐ Rupture ☐ Chest pains ☐ Diabetes ☐ Operations
☐ Shortness of breath ☐ Swollen joints ☐ Chronic cough ☐ Rheumatism ☐ Convulsions
☐ Bleeding disorder ☐ Frequent headaches ☐ Spitting blood ☐ Cerebral hemorrhage or any other serious head injury

**Physical Examination:**

Pulse at rest _____ Blood pressure at rest _____
Pulse after 100 hops _____ Blood pressure after 100 hops _____
Heart: Pulse Rhythm ☐ Regular ☐ Irregular Apical Impulse ☐ Heavy ☐ Normal
Enlargement ☐ Yes ☐ No Murmurs ☐ Yes ☐ No
Lungs: Rales ☐ Yes ☐ No Breasts: Mass ☐ Yes ☐ No Tenderness ☐ Yes ☐ No Discharge ☐ Yes ☐ No
Abdomen: Enlargement of liver ☐ Yes ☐ No
Hernia ☐ Yes ☐ No Remarks: _____
Testicles: Normal ☐ Yes ☐ No Remarks: _____
Reflexes: Pupils _____ Knee jerks _____ Romberg _____ Babinski _____
Remarks for specified medical clearances: _____

EXAMING PHYSICIAN: Physician MUST check one of the boxes below, sign and fill in contact info:
Please check one: I HAVE ☐ I HAVE NOT ☐ Medically cleared this fighter and verified their identification. (Photo ID, Passport or Birth Certificate)

_____ - _____ _____
Licensed Physicians Name and License Number (please print clearly) (please print clearly) Physicians phone number

_____ _____
Physicians Signature Date

**Applicant:**

*I declare under penalty under the laws of the State of Maine that the foregoing information is true and correct; further I realize that any intentional misrepresentation may result in disciplinary action against my license
*I hereby AUTHORIZE the Combat Sports Authority of Maine and/or any physician employed by the Authority to RELEASE any and all medical information and/or personal information with respect to my status and licensure as a participating athlete which may contain any of the Authority's records.
*I further authorize the Combat Sports Authority of Maine to RELEASE this information to any person whom the Authority determines has a need to know. I AGREE that I will fully cooperate with the Authority in making my medical history available including but not limited to giving oral or written reports to the Authority regarding my medical condition, care, and/or treatment.
*I further RELEASE, PROMISE TO HOLD HARMLESS, AND COVENANT NOT TO SUE the Authority or any representative of the Authority on the basis of its attempts to obtain any of the foregoing information, and I further RELEASE, PROMISE TO HOLD HARMLESS, AND COVENANT NOT TO SUE any persons, firms, institutions or agencies providing such information to representatives of the Combat Sports Authority of Maine on the basis of its disclosures. I have signed this release voluntarily and of my own free will.

_____ _____ _____
Signature of applicant Date

# OPHTHALMOLOGICAL EYE EXAM

## Combat Sports Authority of Maine

P.O. Box 10525
Portland, ME 04104
Ph. (207) 712-6615
fax(207)482-0965

### TO BE PERFORMED WITH DILATION AND BY AN OPHTHALMOLOGIST or OPTOMETRIST

NAME: Last First Middle) Ring Name Date of Birth Age

ADDRESS: Street City State Zip Code Last 4 of SSN

HISTORY: - HAS APPLICANT HAD ANY OF THE FOLLOWING CONDITIONS:

(1) Blurred Vision? ☐ YES ☐ NO

(2) Surgical Procedures done to either of their eyes or the tissue around the eyes other than simple sutures of the skin around the eyes?

☐ YES ☐ NO

(3) Has applicant ever been informed by any physician that they had significant eye problems such as retinal detachment, retinal tear, primary or secondary glaucoma, aphakia, pseudophakia, dislocated lens, or cataract? ☐YES NO

If YES, please exlain_____

(4) Eye Disease? ☐ YES ☐ NO

List Nature of Disease:_____

(5) Eye Injury? ☐ YES ☐ NO

List Nature of Injury: _____

(6) Detached retina surgery on either eye?☐ YES☐ NO

List which eye and where and when surgery was performed:_____

EXAMINATION:

| VISION: | Without | With glasses |
|---|---|---|
| Right | | |
| Left | | |

REFRACTION: If either eye is 20/40 or worse

Right_____Sph_____Cyl x_____ Acuity_____

Left _____Sph_____ Cyl x_____ Acuity _____

REMARKS:_____

Intraoccular Tension Right mmHG

Left mmHG

Motility Normal _____ Abnormal _____

Binocular Vision Normal_____ Abnormal _____

| SLIT LAMP EXAM | NORMAL | | ABNORMAL | | SPECIFY ABNORMAILITIES |
|---|---|---|---|---|---|
| | Right | Left | Right | Left | |
| Conjunctive Cornea | | | | | |
| Iris/Pupil | | | | | |
| Lens | | | | | |
| Eyelids | | | | | |

INDIRECT OPHTHALMOSCOPY WITH SCLERAL DEPRESSION (Dilated pupil)

| | NORMAL | | ABNORMAL | | SPECIFY ABNORMAILITIES |
|---|---|---|---|---|---|
| | Right | Left | Right | Left | |
| Disc | | | | | |
| Mascula | | | | | |
| Vessels | | | | | |
| Peripheral Retina | | | | | |

# OPHTHALMOLOGICAL EYE EXAM

(cont)

PHYSICIAN'S REMARKS: _____

_____

_____

_____

The Combat Sports Authority of Maine shall deny, suspend, revoke or place restrictions on the license of any applicant applying for a professional or amateur license to participate in mixed martial arts events regulated by the Combat Sports Authority of Maine, because of any medical or visual condition, including but not limited to the following:

(1) Uncorrected visual acuity of less than 20/200 in either eye or 20/60 with both eyes.
(2) Corrected visual acuity of less than 20/60 in either eye, regardless of its cause.
(3) A visual field of 60 degrees or less extending over one or more quadrants of the visual field.
(4) Presence or history of retinal detachment or retinal tear unless treated by an ophthalmologist and then approved by an Ophthalmologist specified by the Combat Sports Authority of Maine who then assess that the applicant is at no significant risk of further injury to the retina if participation in any of the sports regulated by the Combat Sports Authority of Maine. Such assessment shall occur both within 5 days before and 5 days after any contest.
(5) Presence of primary or secondary glaucoma, whether or not such condition has been treated.
(6) Presence of aphakia, pseudophakia, dislocated lens or cataract in either eye.
(7) Any other visual condition which the Combat Sports Authority of Maine determines would prevent the applicant or licensee from safely participating in any of the sports regulated by the Combat Sports Authority of Maine.

The examining physician is requested to mail a copy of any report, directly to the Combat Sports Authority of Maine of any applicant that has a condition that may preclude them from being licensed.

**PHYSICIAN:**

I have verified applicants identification (Photo ID, Passport or Birth Certificate) and I have read the above criteria and in accordance with the vision requirements as stated therein, have examined the applicant named on page 1 of this eye examination form and

I ☐ DO NOT FIND☐ DO FIND a condition that would preclude them from being licensed to participate in mixed martial arts competitions.

_____ _____ _____

Licensed Physician's name (please print) Physician's license number Physician's signature

_(____)_____ _____

Phone Number Date

**APPLICANT:**

I declare under penalty of perjury under the laws of the state of Maine that the foregoing information is true and correct, further I realize that any intentional misrepresentation may result in disciplinary action against my license.

I hereby AUTHORIZE the Combat Sports Authority of Maine (CSAM) and or any physician authorized by the Combat Sports Authority of Maine to RELEASE any and all medical information and/or personal information with respect to my status and licensure as a professional athlete which may contain any of the CSAM's records. I further authorize the CSAM to RELEASE this information to any person whom the CSAM determines has a need to know. I AGREE that I will fully cooperate with the CSAM in making my medical history available including but not limited to giving oral or written reports to the CSAM regarding my medical condition, care, and/or treatment.

I further RELEASE, PROMISE TO HOLD HARMLESS, AND COVENANT NOT TO SUE the CSAM or any representative of the CSAM on the basis of its attempts to obtain any of the foregoing information, and I further RELEASE, PROMISE TO HOLD HARMLESS, AND COVENANT NOT TO SUE any persons, firms, institutions or agencies providing such information to representatives of the Combat Sports Authority of Maine on the basis of its disclosures. I have signed the release voluntarily and of my own free will.

I further agree that a photographic copy of this AUTHORIZATION shall be valid as the original.

_____ _____ _____

Applicant Name (Print) Applicant Signature Date