PHYSICAL EXAMINATION REPORT

Certification must be dated within 180 days preceding the date of the event to be valid.

SANCTIONING ORGANIZATION

ATHLETE INFORMATION

_____ LAST NAME
_____ FIRST NAME
____/____/____ DATE OF BIRTH

_____ ADDRESS
_____/_____ CITY STATE
_____ ZIP

_____ PHONE
_____ EMAIL

PHYSICIAN SECTION – TO BE COMPLETED BY THE EXAMINING PHYSICIAN

PHYSICAL HISTORY: Mark box if the applicant ever had any of the following conditions:

- ☐ Fainting Spells
- ☐ Cerebral hemorrhage
- ☐ Serious head injury
- ☐ Shortness of breath
- ☐ Frequent headaches
- ☐ Spitting of blood
- ☐ Rupture (hernia)
- ☐ Swollen joints
- ☐ Seizures or Convulsions
- ☐ Chest pains
- ☐ Rheumatism
- ☐ Chronic cough
- ☐ Fracture
- ☐ Diabetes
- ☐ Bleeding disorder
- ☐ High blood pressure
- ☐ Skin disease or rash
- ☐ Communicable disease
- ☐ Surgery, operations, or hospitalizations
- ☐ NONE

Number of knockouts received: _____ **Date of last knockout:** _____ **Longest duration of unconsciousness:** _____

PHYSICAL EXAM – DATE OF EXAM: _____

General Appearance: _____ Height _____ Weight _____ Temperature _____

Disabling scars: _____ Mouth:_____Teeth:_____Tonsils:_____Neck:_____

Pulse at rest: _____

Pulse after 100 hops:_____

Blood pressure at rest:_____

Blood pressure after 100 hops:_____

Blood pressure 2 minutes later:_____

Enlarged glands: ☐ YES ☐ NO

Heart Murmurs: ☐ YES ☐ NO

Pulse rhythm: ☐ REGULAR ☐ IRREGULAR

Apical impulse: ☐ HEAVY ☐ NORMAL

Lungs: Rales: ☐ YES ☐ NO

Breasts: Mass: ☐ YES ☐ NO

Hernia: ☐ YES ☐ NO

Enlargement of spleen: ☐ YES ☐ NO

Enlargement of liver: ☐ YES ☐ NO

Reflexes: Pupils: _____ Knee jerks:_____Romberg:_____Babinski:_____

Skin: Tone: _____ Rash:_____Boils:_____ Other:_____

MEDICAL CLEARANCE TO BE SIGNED BY PHYSICIAN (MUST BE MD OR DO)

I hereby attest the above-named individual to be in good physical health with no observed pre-existing conditions or abnormalities that would prevent his/her ability to compete in a mixed martial arts event.

_____ LICENSED PHYSICIAN PRINTED NAME (MD OR DO)
_____ PHYSICIAN LICENSE NUMBER

_____ ADDRESS
_____ PHONE NUMBER

_____ PHYSICIAN'S SIGNATURE
_____ DATE

SUBMIT TO: GLOBAL COMBAT ALLIANCE **FAX # (804) 441-9037** **EMAIL:** info@gcafights.com
WEBSITE: www.gcafights.com **ADDRESS:** 6415 Jahnke Road, Richmond, VA 23225 **TELEPHONE**: (804) 928-3490