CALIFORNIA AMATEUR MIXED MARTIAL ARTS ORGANIZATION, INC.
INTERNET: www.camomma.org
MEDICAL SUBMISSIONS: medicals@camomma.org
QUERIES: info@camomma.org
FAX: (888) 663-9915

Amateur Mixed Martial Arts and Pankration

FIGHTER MEDICAL REQUIREMENTS (AGES 40+)

The following medical requirements apply to fighter applicants ages 40 and above only. Submit your completed forms to the California Amateur Mixed Martial Arts Organization (CAMO) using the e-mail or fax contact information above. Do NOT use the contact info on each individual form as this will result in a delay in processing. All medicals are time sensitive and must be provided to CAMO within 30 days of appointment/collection date. No medicals will be accepted that are dated more than 30 days prior to submission. No exceptions.

___1. BLOOD TESTS RESULTS – **In addition to** the Blood Test Instructions attached applicants age 40+ must submit the following test results:

- **Complete Blood Count (CBC)**
- **Complete Metabolic Panel**

Expiration: Test results will be valid until the expiration of the applicant's license, if granted.

___1. PHYSICAL EXAMINATION – The physical exam must be completed on the form attached by a licensed physician (MD or DO ONLY).
Expiration: This exam will be valid until the expiration of the applicant's license, if granted.

__2. CARDIOVASCULAR HISTORY & CARDIAC TESTING – The Cardiovascular History From attached is required along with cardiac testing results that provide both myocardial perfusion and echocardiographic structural assessment in the form of an exercise stress echocardiogram (treadmill test).
Expiration: This exam will be valid until the expiration of the applicant's license, if granted.

__3. EKG & EKG SUMMARY – A form is **NOT** included for this step. Results & summary must be provided by the licensed physician (MD or DO ONLY).
Expiration: These will only be required upon initial sign up unless requested otherwise by CAMO.

__4. OPHTHALMOLOGIC EXAMINATION – The Ophthalmologic Examination Form attached may be completed by either an Ophthalmologist or Optometrist.
Expiration: This exam will be valid until the expiration of the applicant's license, if granted.

__5. NEUROLOGICAL EXAMINATION – The Neurological Examination Form attached must be completed by a licensed physician (MD or DO ONLY).
Expiration: This exam will be valid until the expiration of the applicant's license, if granted.

__6. ORGANIC NEUROPSYCHOLOGICAL TESTING – A form is **NOT** included for this step. Formal neurocognitive testing and detailed clearance letter to compete in MMA must be provided by the licensed physician (MD or DO ONLY). This must be provided along with a notation of any deterioration from the baseline (first) assessment.
Expiration: This exam will be valid until the expiration of the applicant's license, if granted.

__**7. MRI & MRI SUMMARY** – MRI Results and Review Summary Form attached must be completed by a licensed physician (MD or DO ONLY).
Expiration: These will be valid for 5 years unless requested otherwise by CAMO.

__**8. MAGNETIC RESONANCE ANIGIOGRAM (MRA) OF THE BRAIN** – A form is **NOT** included for this step. MRA Results and Review Summary must be completed by a licensed physician (MD or DO ONLY).
Expiration: These will only be required upon initial sign up unless requested otherwise by CAMO.

Submission Deadline: The applicant's completed medical packet must be submitted a MINIMUM of 2 weeks prior to fight as they will need to be evaluated and approved prior to competition.

Submit by e-mail to: medicals@camomma.org OR (888) 663-9915
Medical submissions will be forwarded to and processed by *Pro-Am Sports Medicine*.

Note: All medicals, results and forms must be signed off by a licensed physician (MD or DO ONLY). Results signed by a Chiropractor, Physician Assistant or Nurse Practitioner will NOT be accepted.

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Amateur Mixed Martial Arts and Pankration

BLOOD TEST INSTRUCTIONS

Any person applying for a license or the renewal of a license as an amateur mixed martial arts fighter shall present documentary evidence satisfactory to CAMO that the applicant has been administered a blood test, by a laboratory to detect the presence of antibodies both to the human immunodeficiency virus (HIV) and to hepatitis C virus (HCV) and to detect the presence of the antigen of hepatitis B virus (HBV) within 30 days of the date of the application and that the results of all three tests are negative. (AMMA Rules & Regs §605).

CAMO Policy for blood tests:

1. TIME SENSITIVE – The blood tests results must be provided to CAMO **within 30 days of** the blood test being taken. No blood test will be accepted that is dated more than 30 days prior to submission. No exceptions.

2. OFFICIAL RESULTS – All results must show negative results and must be submitted on the computer generated letterhead of the laboratory that administered the tests. Tests not submitted directly from the testing laboratory are subject to verification.

3. EXPIRATION – Blood tests will remain valid until the expiration of the applicant's license, if granted.

4. FALSIFICATION OF DOCUMENTS – Any athlete, coach or licensee found to have manipulated, altered or otherwise falsified a blood test for the purpose of licensure will be suspended immediately and may have their license revoked/denied indefinitely. All suspensions will be reported to a national database and the California State Athletic Commission (CSAC). Fighters will be held responsible for all documents submitted on their behalf.

5. REQUIRED BLOOD TESTS – The required blood tests are as follows (please verify these EXACT tests with your attending nurse, phlebotomist or physician):

1) HIV 4th Generation
2) Hepatitis C Antibody
3) Hepatitis B Surface Antigen

6. LABORATORIES: – CAMO will accept blood tests from licensed and accredited laboratories. Three popular locations for California athletes are as follows:

1) Request-A-Test: 1(888) 732-2348 (24 hr turnaround in most cases)
2) Bio Data Lab: 1(909) 445-9727
3) Advanced Sports Labs: 1(866) 755-6883

7. SUBMISSION INSTRUCTIONS – Submit completed medicals to **medicals@camomma.org** for processing. Medicals will be forwarded to and processed by *Pro-Am Sports Medicine*.

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AMATEUR ATHLETE PHYSICAL EXAMINATION

APPLICANT NAME | RING NAME | TELEPHONE | DATE OF BIRTH

ADDRESS | CITY | STATE | ZIP CODE | COUNTRY

PHYSICAL HISTORY: Have you ever had any of the following conditions?:

☐ None

☐ Fainting spells	☐ Rupture (hernia)	☐ Chest pains
☐ Operations	☐ Shortness of breath	☐ Swollen joints
☐ Rheumatism	☐ Diabetes	☐ Frequent headaches
☐ Convulsions (fits)	☐ Chronic cough	☐ Spitting of blood

☐ Cerebral hemorrhage or serious head injury

Please Explain:_____

Number of knockout losses in your career: _____ Date of last knockout: _____

Have you ever suffered a loss of consciousness for any reason?: ☐ NO ☐ YES

If YES, please explain and provide date(s) and location(s):

When was the last time you took any type of medication or drug? (State what type and when)

Have you ever undergone any type of surgery? ☐ **No** ☐ **Yes** If YES, please describe (State what type and when):

When was the last time you took any type of vitamin supplement? (State what type and when)

Amateur record: Wins _____ Losses _____ Draws _____

Professional boxing/kickboxing: Wins _____ Losses _____ Draws _____

Additional information: _____

PHYSICAL EXAMINATION (ALL FIELDS REQUIRED):

General appearance: _____ Height: _____ Weight: _____ Temperature: _____

Disabling scars: _____ Mouth: _____ Teeth: _____ Tonsils: _____ Neck: _____

Pulse at rest: _____ Pulse after 100 hops: _____

Blood pressure: At rest: _____ After 100 hops: _____ 2 minutes later: _____

Heart Pulse Rhythm:	☐ Regular	☐ Irregular	Lungs: Rales	☐ No	☐ Yes
Murmurs:	☐ No	☐ Yes	Goiter:	☐ No	☐ Yes
Apical impulse:	☐ Normal	☐ Heavy	Enlarged glands:	☐ No	☐ Yes
Enlargement:	☐ No	☐ Yes	Testicles: Normal	☐ Yes	☐ No
Breasts: Tenderness	☐ No	☐ Yes	Hernia:	☐ No	☐ Yes
Breasts: Mass	☐ No	☐ Yes	Abdomen: Enlargement of liver	☐ No	☐ Yes
Breasts: Discharge	☐ No	☐ Yes	Enlargement of Spleen:	☐ No	☐ Yes

Remarks:_____

Reflexes: Pupils _____ Knee jerks _____ Romberg _____

Babinski _____ Skin: Tone _____ Rash _____Boils _____Other:_____

Unhealed wounds:_____

Remarks:_____

EYE HISTORY: Have you ever had any of the following conditions:
Blurred vision? □ **No** □ **Yes** – If YES, please explain in full:

_____

_____

Have you ever had any surgical procedures done to your eye(s) or the tissues around your eye(s) other than simple sutures of the skin around the eye? □ **No** □ **Yes** – If YES, please explain in full:

_____

_____

Have you ever been diagnosed by a physician to have significant eye problems such as retinal detachment, retinal tear, primary or secondary glaucoma, aphakia, pseudophakia, or dislocated lens? □ **No** □ **Yes** – If YES, please explain in full:

_____

_____

EXAMINING PHYSICIAN:
I have examined the above named applicant and **I DO NOT FIND** a condition that would preclude him/her from being licensed as amateur mixed martial arts athlete.

Authorization for release of medical information is attached.

_____ _____
***LICENSED PHYSICIAN'S NAME (print)** ***MEDICAL LICENSE NUMBER**

_____
ADDRESS **CITY** **STATE** **ZIP CODE**

_____ _____
TELEPHONE NUMBER **APPOINTMENT DATE/TIME** (Form incomplete if left blank)

_____
PHYSICIAN'S SIGNATURE (MD or DO ONLY*)

*Must be a licensed physician **(MD or DO ONLY)**. No physician assistant (PA) or nurse (NP) signatures accepted without accompanying physician name, signature, and medical license number.

Please note: Athletes who are **40 years of age or older must also complete the separate **ATHLETE 40+ MEDICAL PACKET** in full.

Submission Instructions:

Submit completed medicals to **1-888-663-9915** or e-mail to **medicals@camomma.org** for processing. Ensure **ALL** fields are completed with the physician in full prior to submission or the submission will be denied. Medicals will be forwarded to and processed by *Pro-Am Sports Medicine*.

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CARDIOVASCULAR HISTORY and EKG REPORT

Only a licensed physician may conduct
Physical and EKG examinations and complete this form.
Please complete this form in its entirety.

This Cardiovascular History shall include a current EKG report performed with the past thirty (30) days.

This examination does not take the place of any other examination required by CAMO. It also does not take the place of any general physical examination, diagnosis, or medical treatment of the applicant. It is solely for the purpose of aiding CAMO in determining whether the applicant's present *cardiac condition* permits him or her to be licensed for competition.

Name of Applicant (Print Name) Date of Birth

Date of EKG Report: _____ Date of this Report:_____

Do you get tired more quickly than your friends do during exercise? **Yes** **No** If YES, please explain: _____
_____

Have you ever had racing of your heart or skipped heartbeats? **Yes** **No** If YES, please explain: _____
_____

Have you been told you had high blood pressure or high cholesterol? **Yes** **No** If YES, please explain: _____
_____

Have you ever been told you have a heart murmur? **Yes** **No** If YES, please explain:
_____
_____

Has any family member or relative died of heart problems or of sudden death before age 50? **Yes** **No** If YES, please explain:_____
_____

Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the past month? **Yes** **No** If YES, please explain: _____
_____

CARDIOVASCULAR HISTORY

APPLICANT NAME: _____

Has a physician ever denied or restricted your participation in sports for any heart problems? **Yes** **No** If YES, please explain: _____
_____

Does the athlete have Normal Sinus Rhythm? **Yes** **No** If NO, please explain: _____
_____

Is the EKG within normal limits? **Yes** **No** If NO, please explain: _____
_____
_____

Based on your personal medical opinion and considering Commission rules, is this applicant cardiologically eligible to be licensed to compete and participate in combative sports? **Yes** **No** If NO, please explain:
_____
_____
_____

Is further referral or additional examinations necessary or recommended? **Yes** **No** If YES, please explain: _____
_____
_____

EXAMINING PHYSICIAN:

_____
*LICENSED PHYSICIAN'S NAME (PRINT) *MEDICAL LICENSE NUMBER

_____
ADDRESS CITY STATE ZIP CODE

_____
TELEPHONE NUMBER DATE/TIME

_____
*PHYSICIAN'S SIGNATURE

*Must be a licensed physician (**MD or DO ONLY**). No physician assistant (PA) or nurse (NP) signatures accepted without accompanying physician name, signature, and medical license number.

Submission Instructions:
Submit completed medicals to **1-888-663-9915** or e-mail to **medicals@camomma.org** for processing. Ensure **ALL** fields are completed with the physician in full prior to submission or the submission will be denied. Medicals will be forwarded to and processed by *Pro-Am Sports Medicine*.

vers. 2023.9.08

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR

CALIFORNIA STATE ATHLETIC COMMISSION
2005 Evergreen Street, Suite 2010 | Sacramento, CA 95815
Phone: (916) 263-2195 | Fax: (916) 263-2197
Website: www.dca.ca.gov/csac| Email:csac@dca.ca.gov

PROFESSIONAL ATHLETE OPHTHALMOLOGIC EXAMINATION

Only a licensed physician who specializes in ophthalmology may conduct this examination and complete this form. Please complete this form in its entirety.

NOTE TO PHYSICIAN: PLEASE EMAIL COMPLETED FORM TO csac@dca.ca.gov OR FAX TO (916) 263-2197.

SECTION 1. APPLICANT INFORMATION (to be completed by applicant)

First Name:	**Middle:**	**Last:**		
Address: *Street:*	*City:*	*State:*	*Zip:*	*Country:*
Home Telephone Number: ( )	**Cellular Telephone Number:** ( )	**Email Address:**		
Male / Female (Circle One)	**Age:**	**Date of Birth: (MM/DD/YY)**		

SECTION 2. EYE HISTORY *(to be completed by applicant)*

	Circle one
Have you ever had blurred vision (not corrected by glasses or contact lenses)?	**YES NO**
Have you ever had any surgical procedures done to your eye(s) or the tissues around your eye(s) other than simple sutures of the skin around the eye (including LASIK)? If yes, please explain in full:	**YES NO**
Have you ever been diagnosed by a physician to have significant eye problems such as retinal detachment, retinal tear, glaucoma, lens or cataract removal, lens implant, keratoconus or dislocated lens? If yes, please explain in full:	**YES NO**
Have you ever had any eye disease? If yes, list nature of diseases or injuries:	**YES NO**
Have you ever had any eye injury? If yes, list nature of diseases or injuries:	**YES NO**
Retinal re-attachment? If yes, please explain:	**YES NO**

SECTION 3. EXAMINATION VISION *(to be completed by examining ophthalmologist)*

VISUAL ACUITY WITHOUT CORRECTION:	**VISUAL ACUITY WITH CORRECTION**:	**VISUAL ACUITY WITH BOTH EYES WITHOUT CORRECTION (known as binocular vision)**:
Right _____/_____	Right _____/_____	_____/_____
Left _____/_____	Left _____/_____	
Remarks: _____	Remarks: _____	Remarks: _____

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ATHLETIC OPHTHALMOLOGIC EXAMINATION

APPLICANT NAME: _____

SECTION 3. EXAMINATION VISION *(continued)*

SLIT LAMP EXAM

	NORMAL Right/Left	ABNORMAL Right/Left	SPECIFY ABNORMALITIES
Conjunctiva Cornea:_____	_____/_____	_____/_____	_____
Iris/Pupil:_____	_____/_____	_____/_____	_____
Lens: _____	_____/_____	_____/_____	_____
Eyelids: _____	_____/_____	_____/_____	_____

INDIRECT OPHTHALMOSCOPY WITH SCLERAL DEPRESSION (Dilated Pupil)

	NORMAL Right/Left	ABNORMAL Right/Left	SPECIFY ABNORMALITIES
Disc: _____	_____/_____	_____/_____	_____
Macula:_____	_____/_____	_____/_____	_____
Lens: _____	_____/_____	_____/_____	_____
Peripheral Retina: _____	_____/_____	_____/_____	_____

Does the applicant have uncorrected visual acuity of less than 20/200 in either eye or 20/60 with both eyes (binocular vision)?	**YES**	**NO**
Does the applicant have corrected visual acuity of less than 20/60 in either eye, regardless of its cause?	**YES**	**NO**
Does the applicant have a visual field of 60 degrees or less extending over one or more quadrants of the visual field?	**YES**	**NO**
Is there a presence or history of retinal detachment or retinal tear?	**YES**	**NO**
Is there a presence of primary or secondary glaucoma?	**YES**	**NO**
Is there a presence of aphakia, pseudophakia, or any other visual condition which would prevent the applicant from safely engaging in combative sports?	**YES**	**NO**

Examining physician: Any of the above conditions **MUST** be reported immediately to the California State Athletic Commission. Please immediately forward a copy of any report, directly to the commission, for any applicant who has a condition that may preclude him/her from safely engaging in combative sports.

PHYSICIAN'S REMARKS:

_____

PHYSICIAN STATEMENT: I have read the above criteria and, in accordance with the vision requirements as stated therein, have examined the applicant named on the this form. ***Based on my personal observation and review of the test results and conditions described above, is it my medical opinion that this applicant has no visual condition that might prevent the applicant from safely engaging in combative sports? If no, please explain:*** _____	**YES**	**NO**

_____ _____
OPHTHALMOLOGISTNAME (print) MEDICAL LICENSE NO.

_____
ADDRESS/CITY/STATE/ZIP CODE

_____
TELEPHONE NO.

_____
PHYSICIAN'S SIGNATURE DATE

_____
APPLICANT'S NAME (print)

_____
APPLICANT'S SIGNATURE DATE

NOTE TO PHYSICIAN: PLEASE EMAIL COMPLETED FORM TO csac@dca.ca.gov OR FAX TO (916) 263-2197.

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Rev. 4/2018

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CALIFORNIA STATE ATHLETIC COMMISSION
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Website: www.dca.ca.gov/csac Email:CSAC@dca.ca.gov

NEUROLOGICAL EXAMINATION REPORT

Only a licensed physician who specializes in neurology or neurosurgery may conduct this examination and complete this form. Please complete this form in its entirety.

NOTE TO PHYSICIAN: PLEASE EMAIL COMPLETED FORM TO csac@dca.ca.gov OR FAX TO (916) 263-2197.

Last Name **First Name** **Date of Birth**

Street Address **City** **State** **Zip Code**

HISTORY

Is there anything in this athlete's past medical history that would cause you to recommend that the athlete not be licensed in California?
☐ **Yes** ☐ **No** If yes, please explain:_____

NEUROLOGICAL EXAMINATION

CRANIALNERVES (1 – 5)

1. **Pupillary size in MM** **OD** _____ **OS** _____ ***Reactivity*** **OD** _____ **OS** _____
   *Note any asymmetry*_____ **N/A** _____**(1)**
2. **Fundus** **OD** _____ **OS** _____ **N/A** _____**(2)**
3. **Eye closure** _____ **N/A** _____**(3)**
4. **Extraocular motility** visual pursuit _____ saccades _____ nystagmus _____
   *Describe any abnormality*_____ **N/A** _____**(4)**
5. **Palate elevation** **N/A** _____**(5)**

MOTOR (6 – 9)

6. **Strength** **RUE** _____ **LUE** _____ **FILE** _____ **LLE** _____ **(0 – 5/5)**
   *List any abnormality*_____ **N/A** _____**(6)**
7. **Tone** **RUE** _____ **LUE** _____ **FILE** _____ **LLE** _____
   (I = increased D = decreased N = normal) **N/A** _____**(7)**
8. **Range of motion** **RUE** _____ **LUE** _____ **FILE** _____ **LLE** _____
   Describe reason for restriction _____ **N/A** _____**(8)**
9. **Abnormal movements** (tics, chorea, choreiform, myoclonus, etc.)_____
   Fasciulations _____
   Describe any abnormal movements _____ **N/A** _____**(9)**

CEREBELLAR (10 – 15)

10. **Finger – nose – finger** *Describe any abnormalities*_____ **N/A** _____**(10)**
11. **Heel – shin** *Describe any abnormalities*_____ **N/A** _____**(11)**
    Abnormal = 3 failures
12. **Rebound check** *Describe any abnormalities*_____ **N/A** _____**(12)**
    Abnormal = 2 failures
13. **Rapid alternating hand movements**
    *Describe any abnormalities*_____ **N/A** _____**(13)**
14. **One foot hop (3 trails, 5 secs ea ft)**
    *Describe any abnormalities*_____ **N/A** _____**(14)**
15. **Romberg** *Describe any abnormalities*_____ **N/A** _____**(15)**

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Rev. 04/2018

NEUROLOGICAL EXAMINATION

APPLICANT NAME: _____

GAIT (16)

16. Gait
Routine Gait _____ Heal Walk _____ Toe Walk _____ Tandem Walk _____
Note any abnormal movements, including upper extremity (ie: dystonic posturing, athetosis)
_____ **N/A _____(16)**

SENSATION(17)

17. Sensation_____ **N/A ____(17)**

DEEP TENDON REFLEXES (18 – 19)

18. Deep Tendon Reflexes _____ **N/A _____(18)**
19. Babinski _____ **N/A _____(19)**

OTHER OBSERVATIONS (20)

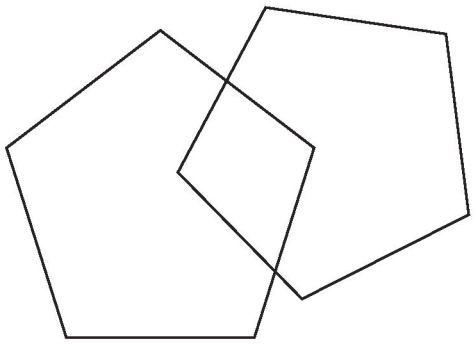
20. List any other symptoms or evidence of neurological abnormalities from history or observations.

_____ **N/A _____(20)**

MENTAL STATUS EXAMINATION

MINI-MENTAL STATUS EXAM (1 - 9)

		Maximum Score	Score
1.	What is the (year) (season) (date) (month)	5	_____
2.	Where are we (state) (county) (city) (hospital) (floor)	5	_____
3.	Name 3 objects: (e.g., cow, apple, bus) – one second to say each Then ask applicant all three after you have said them. (One point for each correct answer.) Then repeat them until he/she learns all 3. Count trials and record. Trials = _____	3	_____
4.	Serial 7's. (One point for each correct.) Stop after 5 attempts	5	_____
5.	Ask for the 3 objects repeated above (one point for each correct)	3	_____
6.	Name a pencil and a watch	2	_____
7.	Repeat: "NO IFS, ANDS, OR BUTS"	1	_____
8.	Follow a 3-stage command: "TAKE A PAPER IN YOUR RIGHT HAND. FOLD IT IN HALF, AND PUT IT ON THE FLOOR"	3	_____
9.	Copy Design	1	_____



TOTAL SCORE _____
(0-21 suggests cognitive impairment) **N/A____ (1-9)**

NEUROLOGICAL EXAMINATION

APPLICANT NAME: _____

EXAMINING NEUROLOGIST OR NEUROSURGEON

o As a licensed physician specializing in **neurology or neurosurgery** *(circle one)* **I DO or DO NOT** *(circle one)* believe that this applicantcould be permitted to be licensed in California.

Is further referral necessary? _____

Are additional exams needed? _____

I certify under penalty of perjury under the laws of the State of California that I am a licensed physician and that I specialize in neurology or neurosurgery.

_____ _____
Licensed Neurosurgeon or Neurologist's Name (Print) Medical License Number

_____ _____
Signature of Neurosurgeon or Neurologist Date

_____ _____
(Street Address) City State Zip ( ) Phone #

The athlete is required to sign the authorization and acknowledgement below in either English or Spanish. The California State Athletic Commission is a public health authority, as defined in 45 CFR 164.501, exempt from HIPAA, and is authorized by Business and Professions Code Section 18600, et seq to collect information about the applicant's physical condition. Authority to provide the Athletic Commission with information requested on this examination is established pursuant to Section 18640, 18642, 18643, 18660, and 18711 of the California Business and Professions Code. All information is mandatory for licensure. Failure to provide this mandatory information will result in denial of a license.

NEUROLOGICAL EXAMINATION ACKNOWLEDGEMENT

This examination is required for licensure and renewal of licensure of every professional athlete in the State of California.

I understand:

1. That the purpose of this screening examination is to detect possible early neurological changes resulting from cumulative head trauma which occur over extended periods of time and also changes that may affect my ability to engage in a professional boxing and/or martial arts match. This examination may uncover neurological findings that might hinder my ability to defend myself in a professional boxing and/or martial arts match.
2. That this examination does not predict possible future changes such as dementia, language difficulties, and problems with movement and coordination. Nor does it rule out the possibility of acute head trauma, such as subdural hematoma.
3. That this examination does not take the place of the general physical examination or diagnosis or medical treatment necessary for my general health or for any physical or mental condition I may otherwise have.
4. That the physician who is conducting this examination is not my personal physician and is not providing medical services to me.
5. That the results of this examination will be forwarded to the California State Athletic Commission for those purposes.
6. That any additional examinations, diagnostic procedures or treatment, including those which may be necessary for licensure as determined by the commission for the diagnosis and treatment of any physical or mental condition I may have, will only be done at my request and at my expense.

I have read and understand the statements made above.

_____ _____
Signature of Athlete **Date**

NOTE TO PHYSICIAN: PLEASE EMAIL COMPLETED FORM TO csac@dca.ca.gov OR FAX TO (916) 263-2197.

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CALIFORNIA STATE ATHLETIC COMMISSION
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Website: www.dca.ca.gov/csac Email: CSAC@dca.ca.gov

MRI REVIEW SUMMARY

Only a licensed physician who specializes in neurology or neurosurgery may conduct neurological examinations and complete this form. Please complete this form in its entirety.

NOTE TO PHYSICIAN: PLEASE EMAIL COMPLETED FORM TO csac@dca.ca.gov OR FAX TO (916) 263-2197.

This examination does not take the place of any other examination required by the California State Athletic Commission (Commission). It also does not take the place of any general physical examination, diagnosis, or medical treatment of the applicant. It is solely for the purpose of aiding the Commission in determining the *neurological condition of* the applicant and if he or she is fit to be licensed to compete in combative sports.

Only MRI scans conducted on a (at a minimum) 1.5 Tesla MR Machine are acceptable. The machine must be equipped with capabilities that include fast spin echo and FLAIR imaging. Image sequences should include axial T1, T2, FLAIR images and gradient echo axial; coronal images should be performed as a T2 coronal; and a single sagittal T1 sequence.

Only diagnostic reports that are performed on machines with these specifications are accepted by the Commission. If the examination was not conducted on a machine that meets these specifications, do not complete this form.

_____ _____
Name of applicant (Print Full Name) **Date of Birth**

Date of MRI Diagnostic Report: _____ Date of this report: _____

Is the MRI examination within normal limits? ☐ **Yes** ☐ **No** If no, please explain: _____

_____

Is further referral or additional examinations necessary or recommended? ☐ **Yes** ☐ **No** If yes, please explain: _____

_____

NOTICE TO PHYSICIAN: No clearance may be given by you to any applicant who has signs of or has suffered cerebral hemorrhage or any other serious head injury. Any such signs or observations must be reported to the Commission immediately. You may not clear an applicant to compete that demonstrates these signs or symptoms unless so instructed by the Commission.

Based on your personal medical opinion and considering Commission rules, is this applicant neurologically eligible to be licensed to compete and participate in combative sports? ☐ **Yes** ☐ **No** If no, please explain: _____

_____

LICENSED PHYSICIAN'S NAME (print)	MEDICAL LICENSE NO.	APPLICANT NAME (print)
ADDRESS / CITY / STATE / ZIP CODE		APPLICANT SIGNATURE
TELEPHONE NO.	DATE/TIME	PERSON WHO ASSISTED'S NAME (print)
PHYSICIAN'S SIGNATURE		PERSON WHO ASSISTED'S SIGNATURE

NOTE TO PHYSICIAN: PLEASE EMAIL COMPLETED FORMS TO csac@dca.ca.gov OR FAX TO (916) 263-2197

PB003
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