TEXAS DEPARTMENT OF LICENSING AND REGULATION
P.O. Box 12157 - Austin, Texas 78711-2157
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www.tdlr.texas.gov - Combative.Sports@tdlr.texas.gov

COMBATIVE SPORTS PROFESSIONAL CONTESTANT LICENSE APPLICATION

PURSUANT TO TITLE 13, OCCUPATIONS CODE, CHAPTER 2052

RECEIPT NUMBER	EVENT CODE	FEE AMOUNT	PAYMENT AMOUNT	MONEY TYPE
		$20.00 All fees are non-refundable		

DO NOT WRITE ABOVE THIS LINE

1. Full Name:

_____ _____ _____
Last Name First Name Middle name

2. Mailing Address:

_____
Number , Street, Suite No., Apt No or P. O. Box

_____ _____ _____
City State Zip Code

3. Phone Number:

(_____) _____

4. Social Security No.

_____ - _____ - _____
(Foreign Nationals may submit Passport #)

5. Date of Birth:

_____ - _____ - _____

6. Place of Birth:

_____

7. Female ☐ Male ☐

8. Email Address:

_____

9. Promoter Name:

_____

10. Event Date:

_____ / _____ / _____

I certify that all information is true and correct. I understand that providing false information on this application may result in sanctions up to and including denial or revocation of the license I am requesting, and in the imposition of the administrative penalties. I will comply with all applicable provisions of Chapters 51 and 2052, Texas Occupations Code, and 16 Texas administrative Code, Chapters 60 and 61. I understand that this license is not transferable. If the license is issued, I agree to furnish to the Texas Department of Licensing and Regulation any change in information provided on this form within Thirty (30) days of the change.

_____ _____
Applicant Signature Date

APPLICANT NAME (Please print) _____

PROFESSIONAL CONTESTANT'S MEDICAL EXAMINATION - PART 1

TO BE COMPLETED BY A LICENSED MEDICAL DOCTOR ONLY
Forms completed by a physician assistant or a nurse practitioner will NOT be accepted

Medical Allergies _____
Are you taking any medication? __ YES __ NO; EXPLAIN _____
Previous Hospitalization(s) or surgery (Give dates) _____

Results of the following blood tests must be attached to this application:
- □ **Hepatitis B surface ANTIGEN**
- □ **Hepatitis C ANTIBODY**
- □ **HIV ANTIBODY**

ALL MEDICAL AND LAB TEST RESULTS MUST BE DATED AND TAKEN WITHIN THE LAST 6 MONTHS BEFORE THE APPLICATION IS SUBMITTED.

Answer All Questions Below (circle each answer)

(A) BLEEDING TENDENCIES	**YES**	**NO**	**(L) SEIZURES AND CONVULSIONS**	**YES**	**NO**
(B) DIABETES	**YES**	**NO**	**(M) ASTHMA**	**YES**	**NO**
(C) HERNIA	**YES**	**NO**	**(N) HIGH BLOOD PRESSURE**	**YES**	**NO**
(D) HEART DISEASE	**YES**	**NO**	**(O) TUBERCULOSIS**	**YES**	**NO**
(E) SICKLE CELL DISEASE	**YES**	**NO**	**(P) MONONUCLEOSIS**	**YES**	**NO**
(F) KIDNEY DISEASE	**YES**	**NO**	**(Q) RHEUMATIC FEVER**	**YES**	**NO**
(G) HEPATITIS	**YES**	**NO**	**(R) COUGH**	**YES**	**NO**
(H) SKIN DISEASE	**YES**	**NO**	**(S) PSYCHIATRIC PROBLEMS**	**YES**	**NO**
(I) HEADACHES	**YES**	**NO**	**(T) CONTACT LENSES**	**YES**	**NO**
(J) JOINT INJURY OR DISLOCATION	**YES**	**NO**	**(U) NUMBER OF TIMES KO'D**	_____	
(K) CONCUSSION/UNCONSCIOUSNESS	**YES**	**NO**	**(V) KIDNEY, LUNG, TESTICLE, EYE REMOVED**	**YES**	**NO**

Do you have any other information concerning your health, past or present, which is NOT COVERED by the questions above? _____

A PERSON AGE 36 OR OLDER MUST ALSO SUBMIT A FAVORABLE:
- □ **EEG (Electroencephalography) AND**
- □ **EKG (Electrocardiogram)**

EXAMINING MD or DO NAME (Please print) _____

MEDICAL LICENSE # _____
(must be licensed in a State, District or Territory of the United States)

ADDRESS _____ CITY _____

STATE _____ ZIP _____ PHONE NUMBER _____

MD or DO SIGNATURE _____ DATE _____

APPLICANT SIGNATURE_____ DATE_____
APPLICANT NAME (Please Print)_____

PROFESSIONAL CONTESTANT'S MEDICAL EXAMINATION - PART 2

EARS

AUDITORY CANALS	**RIGHT _____ LEFT _____**
DRUMS	**RIGHT _____ LEFT _____**
AUDITORY ACUITY FOR CONVERSATIONAL VOICE	**RIGHT _____ LEFT _____**

NOSE (note deformity, old fractures, deviated septum, other)

_____

OROPHARYNX

TONSILS _____ GUM _____ TEETH _____
TONGUE (record any deviation or tremors) _____
NECK (note masses, pulse, thyroid, carotid, bruits, and limitation of motion)
_____

THORAX

LUNGS _____
HEART (size, murmurs, arrhythmia) _____
HEART RATE _____ BLOOD PRESSURE (S) _____ (D) _____
PULSE RATE _____ IMMEDIATELY AFTER 20 HOPS _____
2 MINUTES AFTER EXERCISE _____

ABDOMEN

NOTE SCARS _____
LIVER, KIDNEY, SPLEEN (enlarged, tender) _____
INGUINAL AREA (tenderness, hernia) _____

SKIN (note staph infection, cyanosis, hair distribtion_____

LYMPHATIC SYSTEM _____

MUSCULOSKELETAL SPINAL SYSTEM (curvature, posture, tenderness, limitation of motion)
_____

EXTREMITIES (deformity, tenderness, joint mobility) _____

NEUROLOGICAL

GAIT _____ RHOMBERG _____
FINGER TO NOSE _____ KNEE JERKS _____
BICEP JERKS _____ BABINSKI _____
BRUDZINSKI _____ CRANIAL NERVES _____

I hereby certify that I have examined _____
(please print applicant's name)

Date of the exam: _____ , _____ _____
Month Day Year

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

MD or DO SIGNATURE _____ DATE _____

APPLICANT SIGNATURE _____ DATE _____

APPLICANT 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
VISUAL ACUITY (WITHOUT CORRECTION)	N _____	N _____
	F _____	F _____
EXTERIOR EXAM	_____	_____
ANTERIOR EXAM	_____	_____
FUNDI	_____	_____
EXTRAOCULAR MUSCLES	_____	_____
VISUAL FIELDS (Confrontation)	_____	_____
TONOMETRY	_____	_____

EXPLAIN ABNORMAL FINDINGS

_____

DIAGNOSIS _____

_____

I hereby certify that a dilated exam was performed on:_____
(please print applicant's name)

Date of the exam: _____ , _____ _____
Month **Day** **Year**

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

Ophthalmologist or Optometrist NAME _____
(please print)

LICENSE # _____
(must be licensed in a State, District or Territory of the United States)

ADDRESS _____ **CITY** _____

STATE _____ **ZIP** _____ **PHONE NUMBER** _____

OPHTHAMOLOGIST or OPTOMETRIST SIGNATURE _____ **DATE** _____

APPLICANT SIGNATURE _____ **DATE** _____