



**PART ONE – To be completed by the examining medical practitioner**

## Certificate of Fitness

Full name of the Contestant/Participant: \_\_\_\_\_

Address: \_\_\_\_\_

Suburb: \_\_\_\_\_ State: \_\_\_\_\_ Post Code: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  Male  Female

I certify that this person is **FIT / UNFIT** (*delete one*) to compete or participate in a combat sports contest.

Signed: \_\_\_\_\_ Print Name: \_\_\_\_\_  
*Medical Practitioner* *Medical Practitioner*

Provider Number: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Medical practitioner's stamp:

## PART TWO – Medical and Competition History

### Division 1 – Personal Details and Competition History

(To be completed by the CONTESTANT/PARTICIPANT)

Please use BLOCK LETTERS

FAMILY NAME		GIVEN NAMES		EXAMINATION DATE	
RESIDENTIAL ADDRESS					POST CODE
HOME PHONE		MOBILE			
DATE OF BIRTH (dd/mm/yyyy)		GENDER		<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE

1. CAREER HISTORY			
Career Results	Wins	Losses	Draws
Amateur			
Professional			

2. HAVE YOU SUFFERED ANY INJURIES WHILE COMPETING?  YES  NO

3. HAVE YOU HAD ANY HEADACHES, VOMITNG OR PROBLEMS WITH SPEECH OR VISION AFTER A CONTEST?  YES  NO

### Division 2 – Medical History

(To be completed by the MEDICAL PRACTITIONER)

		Yes	No			Yes	No			Yes	No
1.	Have you at present any: a. illness b. disability			13.	Tuberculosis			26.	Hepatitis or other jaundice Liver disease		
2.	Are you now receiving medicine, drugs, or other treatment			14.	Asthma Other lung disease			27.	Rupture Hernia Swollen /painful testicles		
3.	Has an accident or illness kept you off work for more than one week			15.	Deafness Tinnitus			28.	Any skin trouble Tendency to bruise or bleed easily		
4.	Have you ever had any operations			16.	Visual problems Do you wear glasses or contact lens			29.	Concussion Severe head injury Loss of consciousness		
5.	Have you ever been a patient in any hospital: a. Medical b. Other			17.	Fainting attacks Blackouts			30.	Knee injury Ankle injury Back injury Other joint injury or dislocation		
<b>Have you ever had or are you now suffering from any of the following?</b>				18.	Fits or convulsions Epilepsy Giddiness			31.	Fractured bones Chipped bones		
6.	Rheumatic fever Heart disease			19.	Severe headaches Migraines			32.	Paralysis (including polio)		
7.	Palpitations or pounding heart			20.	Nervous trouble Severe depression Mental illness Attempted suicide			33.	Any other injury, illness or disability		
8.	High or low blood pressure			21.	Kidney disease Bladder disease Pain passing urine Blood in your urine			34.	<b>(Females)</b> Are you pregnant?		
9.	Swollen or painful joints (other than through injury)			22.	Frequent indigestion						
10.	Shortness of breath			23.	Ulcer of stomach Ulcer of duodenum						
11.	Pneumonia Bronchitis or pleurisy			24.	Gall bladder trouble Gall stones						
12.	Coughing blood Coughing up phlegm			25.	Sugar diabetes						

## Medical Practitioner's Notes on History

(A "Yes" answer to any question requires the medical practitioner to state the question number and comment here)

35. Over the past five (5) years has the Contestant/Participant, either occasionally or regularly, taken any stimulants, sedatives, medications or drugs by mouth or by injection?

YES  NO

If "Yes", provide details and, if prescribed by a doctor, include the relevant particulars in question 36 below.

36. Over the past five (5) years has the contestant had any medical examination, advice, treatment or been in hospital?

YES  NO

If "Yes", provide particulars of each instance (including x-ray, electrocardiogram or other special tests) in the table below.

Date	Name and address of doctor and/or hospital	Reason (If illness or injury, give duration and date of recovery)
37. Details of photographic identification provided to the medical practitioner:	Drivers Licence #	Passport #

## PART THREE – Record of Medical Examination prior to Registration/Renewal of Registration

(To be completed by the MEDICAL PRACTITIONER)

Physical Examination		Normal	Abnormal	Physical Examination		Normal	Abnormal
1.	a. Head, face, scalp b. Neck R.O.M.			11.	Ophthalmoscopic examination		
2.	a. Nose deformity b. Nose airway			12.	Chest, lungs		
3.	a. Mouth, throat b. Speech			13.	Heart (if ECH performed, note result in section & enclose F MED 53)		
4.	a. Teeth, gums b. Dentures Yes / No			14.	Vascular system (include veins)		
5.	a. Ears – general b. Ears – hearing			15.	Abdomen (include hernial orifices)		
6.	Tympanic membranes			16.	Endocrine system		
7.	Eustachian tubes			17.	External genitalia		
8.	Eyes – general			18.	a. Feet b. Limbs R.O.M. c. Gait		
9.	a. Visual fields b. Eye gaze			19.	A. Spine b. Trunk R.O.M. c. Posture (standing)		
10.	Eye movement			20.	a. Nervous system b. Cranial nerves		
21.	a. Cerebellum function b. Body balance/ coordination			30.	Height: (cm)		
22.	a. Muscle tone b. Muscle strength c. Sensation			31.	Chest: (cm)                      Exp                      Ins		
23.	Reflexes			32.	Waist: (cm)		
24.	Skin			33.	Urinalysis:                      Albumin                      Sugar		
25.	Lymphatic system Lymph glands in neck axillae or inguinal			34.	Weight: (kg)		



26.	Emotional stability			35.	Blood Pressure:	Systolic	Diastolic
27.	Other			36.	Eye Colour:		
28.	Identifying marks			37.	Distant vision:	R6 L6	Corr 6 to 6
					Near vision:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
29.	Frame: Large Medium Small			38.	Has a MRI Scan been conducted?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
					Is the MRI satisfactory?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
					Any further testing required?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Please attach a copy of the radiologist's report.</b>							

**39. Medical Practitioner's Notes on Medical Examination**  
(Provide details of any abnormality noted and enter the relevant question number before each comment.)

40. Is any further testing required?  YES  NO

**Neuro/Psychological Examination**

41.	Is there any evidence of a change in character?	<input type="checkbox"/> YES <input type="checkbox"/> NO
42.	Has the contestant a good memory for recent events and, in particular, recent contests?	<input type="checkbox"/> YES <input type="checkbox"/> NO
43.	Does the contestant follow conversation with attention and intelligence?	<input type="checkbox"/> YES <input type="checkbox"/> NO
44.	Is there any evidence of a tendency to violence outside the competitive arena?	<input type="checkbox"/> YES <input type="checkbox"/> NO

**45. Medical Practitioner's Notes on Neuro/Psychological Examination**  
(State whether further assessment is required.)

**46. Particulars of any Disabilities**

**Contestant/Participant's Declaration and Release of Medical Information Authorisation**

I declare that the information provided in this Certificate of Fitness is true and complete to the best of my knowledge and belief.

I authorise (insert name of MEDICAL PRACTITIONER) \_\_\_\_\_ to provide personal medical information to the Western Australian Professional Combat Sports Commission for administering the Professional Combat Sports Act 1987 and authorise the medical practitioner to obtain details of my medical records from previous medical practitioners if required.

Contestant/Participant name (print) \_\_\_\_\_ Signed \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

**I have completed the above Medical History and have witnessed the contestant/participant signature.**

Medical Practitioner name (print) \_\_\_\_\_ Signed \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

**Medical Practitioner's Summary**

Name of examined contestant \_\_\_\_\_

Do you consider the contestant to be fit to participate as a Contestant/Participant in boxing /combat sports contests?  
 YES  NO  Further Assessment Required

Any comments: \_\_\_\_\_

Signature of medical practitioner \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

Name of medical practitioner (please print) \_\_\_\_\_