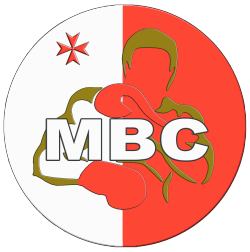

MALTA BOXING COMMISSION
10 Christef Flats, Triq il-Maskli, Qawra, San Paul il-bahar, Malta
Tel: +356 99452555 – Tel: +356 79452555
Web: www.maltaboxingcommission.com E.Mail: admin@maltaboxingcommission.com

BOXERS MEDICAL EXAMINATION FORM

(To be completed at time of application and annually when licence fee due)

Note to Applicant:
This examination must be carried out by a Qualified Medical Practitioner, currently on the Medical Register.

Note to Examining Doctor:
This form, when completed, should be forwarded to the Malta Boxing Commission representative or to the above address. The Fee for the examination is payable by the Boxer.

QUESTIONS TO BE ASKED BY AN EXAMINING DOCTOR

Full Personal Name_____
(Block Letters)

Professional Boxing Name (If different from above)_____
(Block Letters)

Address_____
(Block Letters)

Date of Birth _____ Marital Status _____

Telephone/Mobile:_____ E.Mail:_____

Occupation (Other than Boxer) _____

Manager or proposed Manager_____

Have you held a licence previously _____

If so, give past record of contests:

No. _____ Won _____ Lost _____ Counted Out _____ Stopped _____

Amateur/unlicensed record if any _____

1. Are you in good health as far as you know_____

2. Have you suffered at any time any serious illness, injury, accident or disability. if so give details

_____

3. Have you suffered at any time from any of the following (If so give full details – Doctors consulted and results of investigations.

Headaches, blackouts or fits _____

Anxiety states or depressions _____

Paralysis or any other mental or nervous diseases _____

Have you seen a psychiatrist or taken tranquillisers _____

4. Visual disturbances, such as diplopia, blurring vision, or do you wear glasses or contact lenses

_____

5. Any ear discharge, deafness, etc. _____

6. Heart disease, high blood pressure, heart murmurs, varicose veins, rheumatic or scarlet fever

_____

7. Any asthma, bronchitis, pneumonia, or T.B, sinusitis or any difficulty in nasal breathing _____

8. Any chronic indigestion, stomach or duodenal ulcers, gall bladder or liver disease, appendicitis, hernia, bowel disorders, Crohn's Disease, haemorrhoids etc. _____

9. Any kidney or bladder problems, diabetes, renal colic, haematuria, venereal infections or prostatitis _____

10. Any bone or joint problems, e.g. hand injuries, fractures, etc. _____

11. Any skin diseases _____ Allergies _____

12. Are you or have you been attending your doctor or hospital regularly for any reason _____

13. Do you take tablets/medicines, etc, regularly _____

14. Date and result of last X-ray (if any) _____

15. Any other investigations, i.e. blood tests, X-rays, E.C.G., E.E.G. _____

Number of cigarettes smoked per day _____

Daily alcohol intake _____

Family History

Father (age and health) _____ Mother (age and health) _____

Brothers (age and health) _____ Sisters (age and health) _____

I hereby give my consent to the Malta Boxing Commission and it's Medical Officers to contact my doctor to obtain medical information pertaining to my application to box.

Signature of Boxer _____

Signature of Doctor _____

EXAMINATION

Height _____ Weight _____

Describe build, etc. If overweight, is excess evenly distributed _____

_____

If he/she has had a MRI/MRA Brain Scan, indicate date. _____

Pulse _____ Apex beat _____

Blood pressure (if above 140/90 please record 3 further readings at 5 minute intervals) _____

Heart sounds _____

Any murmurs _____

If so describe _____

Any varicose veins _____ Exercise tolerance _____

Respiratory System

Chest movements _____ Trachea _____

Percussion Notes _____ Air Entry _____ Breath Sounds _____ Added Sounds _____

Abdomen

Any scars, tenderness or masses – if so, describe _____

Are liver, spleen and kidney palpable _____

Hernia orifices _____ Genitalia _____ Urine _____

Central Nervous Systems

Cranial nerves _____ Pupils _____ Optic fundi _____

Nystagmus _____ Rombergism _____

Limbs

Tone _____ Power _____ Co-ordination _____ Sensation _____

Reflexes _____ Plantar responses _____

Any psychoneurosis _____ If yes, describe _____

Skeletal System

Cervical Spine _____Shoulders _____ Elbows _____ Wrists and hands _____

Lumbar Spine _____ Hips _____ Knees _____ Ankles _____

HIV & Hepatitis Vaccination and Screening

HIV Test:- Test date _____**Forward Laboratory results to MBC**

Hepatitis C Antigen:- Test date _____**Forward Laboratory results to MBC**

Hepatitis B Antigen:- Test date _____ **Forward Laboratory results to MBC**

Hepatitis B Surface Antibody:- Test Date _____**Forward Laboratory results to MBC**

Hepatitis B Vaccination:- Date of first dose_____

Please note that every Boxer must complete the Hepatitis B Vaccination course, the course consists of three doses. The second dose is given one month after the first dose and the third dose is given five months after the second dose. This course must be completed and evidence of dates must be forwarded to the Malta Boxing Commission head office.

Ears

Drum _____ Hearing _____ Any otitis _____

NOTE TO EXAMINING DOCTOR – If any abnormality noted, please investigate further and refer all relevant documents to the Commission's Chief Medical Officer at the Head Office of the Malta Boxing Commission with this form.

Date of examination _____

I AM SATISFIED AS TO THE CORRECT IDENTITY OF THE EXAMINEE, WHO HAS PRODUCED FOR ME PHOTOGRAPHIC ID SUCH AS HIS OR HER'S BOXER'S LICENCE, DRIVING LICENCE OR PASSPORT, OR ALTERNATIVELY, I CONFIRM HIS OR HER LIKENESS BY SIGNING THE ATTACHED PHOTOGRAPH.

Signature and stamp of examining doctor _____

COMMENTS (Any):

TO BE COMPLETED BY THE CHIEF MEDICAL OFFICER (OR HIS DEPUTY)

CONFIDENTIAL

To the stewards of the Malta Boxing Commission

The following recommendation is made in the case of:

Name _____

(a) Licence granted or renewed _____

(b) Licence not granted/renewed _____

Date: _____ Signature _____

Eye Test:

Eye test to be completed by an Opthalmic Optician/Consultant

Visual standards **(Snellen's type figures without glasses)** _____

Visual fields _____

Ocular tension _____

Ocular movements _____

Ophthalmoscopic examination (with special attention to retinal defects) _____

Date of examination _____

I AM SATISFIED AS TO THE CORRECT IDENTITY OF THE EXAMINEE, WHO HAS PRODUCED FOR ME PHOTOGRAPHIC ID SUCH AS HIS OR HER'S BOXER'S LICENCE, DRIVING LICENCE OR PASSPORT, OR ALTERNATIVELY, I CONFIRM HIS OR HER LIKENESS BY SIGNING THE ATTACHED PHOTOGRAPH.

Signature and stamp of Optician/Consultant _____