



**New Brunswick
Combat Sport Commission**

**La Commission des sports de
combat du Nouveau-Brunswick**

***New-Brunswick Combat Sport Commission
ANNUAL MEDICAL EXAMINATION - REFEREE***

Name in full		Age	Date of Birth ____-____-____
Address, City, Province	Postal Code	Phone #: (____) _____	E-MAIL: _____

<i>PAST MEDICAL STORY:</i>
<i>MEDICATION:</i>
<i>ALLERGIES:</i>
EYE EXAM BY OPHTHALMOLOGIST OR OPTOMETRIST: (please provide copy of report)

<i>GENERAL:</i>		
To your knowledge is there any medical condition or disorder that would require attention or evaluation before allowing this applicant to be a referee in a combat sport event.		
	YES	NO
If answered yes please provide a copy of examination and conclusion.		
Applicant is considered FIT to referee in combat sport matches?		
	YES	NO
Signature of <i>PHYSICIAN</i> : _____		
Date of declaration: ____-____-____		

PLEASE RETURN FORM TO: PO BOX 8056, DIEPPE N-B, E1A 9M7