



New Brunswick
Combat Sport Commission

La Commission des sports de
combat du Nouveau-Brunswick

MEDICAL EXAMINATION WITHIN 90 DAYS OF FIGHT

FOR LICENSED FIGHTERS

Name in full _____ Age _____ Date of Birth _____

Address _____ City _____ Province _____

Postal Code _____ Phone #: (____) _____ - _____ E-Mail: _____

LICENCE #: _____

VISION EXAMS : TO BE COMPLETED BY OPHTHALMOLOGIST OR OPTOMETRIST (REPORT WITHIN 90 DAYS OF FIGHT***)

Uncorrected vision R _____ L _____

Corrected vision R _____ L _____

Pupils Equal?

YES

NO

Symmetrical reaction to light?

YES

NO

Funoscopic examination normal?

YES

NO

Normal Visual Field?

YES

NO

If evaluation reveals any abnormalities please describe:

OPHTHALMOLOGIST OR OPTOMETRIST (print name please): _____

SIGNATURE OF OPHTHALMOLOGIST OR OPTOMETRIST: _____

DATE OF EXAM: _____

Stamp or address with contact number:

GENERAL EXAM : TO BE COMPLETED BY A PHYSICIAN

EKG: (for fighters 35 years old and over only***) : REPORT WITHIN 90 DAYS OF FIGHT

BLOOD WORK: ARE TO BE REPEATED EVERY 3 MONTHS TO MAINTAIN ELIGIBILITY TO FIGHT***

(please provide copy of lab report)

Hep B Screening *** Surface Antigen, Surface Antibody and Core Antibody

Hep C Screening

HIV Screening

Syphilis Screening

To your knowledge is there any new medical condition or disorder since the last medical examination that would require additional attention or evaluation by a physician?

YES

NO

If answered yes please provide a copy of examination and conclusion.

NAME OF FIGHTER: _____

Applicant is considered FIT to take part in combat sport contest?

YES

NO

PHYSICIAN (print name please): _____

SIGNATURE OF PHYSICIAN: _____

DATE OF EXAM : _____

Stamp or address with contact number:



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