South Carolina Department of Labor, Licensing and Regulation
South Carolina State Athletic Commission
110 Centerview Dr. • Columbia • SC • 29210
P.O. Box 11329 • Columbia • SC 29211-1329
Phone: 803-896-4571 • Contact.Athl@llr.sc.gov • Fax: 803-896-4350
llr.sc.gov/ath

Application Instructions for Boxing, Kick Boxing, Off the Street Boxing & Wrestling Referees

This application has several sections that require separate entities to complete remit their applicable section.

The **Application Form** (Pages 1-4):

- Remit with a check or money order in the amount applicable to the type of license being applied for.
- Send a copy of a **valid and legible** photo ID. Acceptable forms of identification are a Driver's License, a State Issued ID or a Passport.
- Copy of social security card
- The Verification of Lawful Presence form requires a notarized signature.
- Medical Information Release Form
- Boxers and MMA Fighters need to submit their certification from ABC.

The **Physical Exam Form**:

- **ALL Wrestlers are required to submit an annual physical.**
- **Boxing, MMA, and Kick Boxing applicants over thirty-five (35) years of age are required to submit a physical/EKG. The M.D./D.O. will fill it out, sign and remit to our office. Forms sent in by applicant will not be accepted.**

The **Eye Exam Form:**

- **Wrestlers are not required to submit this form.**
- Applicant fills out page 1 and takes both pages to the optometrist's office to have the physician fill it out, sign and remit to our office. Forms sent in by applicant will not be accepted.

Blood Tests:

- **Wrestlers are not required to have blood tests submitted.**
- You are required to have blood tests for HIV, Hep B and Hep C; results need to be sent to our office before you are able to fight.

STATE OF SOUTH CAROLINA
DEPARTMENT OF LABOR, LICENSING AND REGULATION

VERIFICATION OF LAWFUL PRESENCE IN THE UNITED STATES
AFFIDAVIT OF ELIGIBILITY

Pursuant to Section 8-29-10, *et seq.* of the South Carolina Code of Laws (1976, as amended), the Department of Labor, Licensing and Regulation must verify that any person who applies for a South Carolina license is lawfully present in the United States. Complete and sign this affidavit of eligibility. The information provided is subject to verification.

Section A: LAWFUL PRESENCE in the United States.

The undersigned _____, of _____
(Print clearly First, Middle, and Last name) (Home Address, City, State, and Zip Code)
being first duly sworn deposes and states as follows:

Check only one box:

1. ☐ I am a United States citizen; or
2. ☐ I am a Legal Permanent Resident of the United States eighteen years of age or older; or
3. ☐ I am a Qualified Alien or non-immigrant under the Federal Immigration and Nationality Act, Public Law 82-414, eighteen years of age or older, and lawfully present in the United States.
4. ☐ Other:_____Please submit any documentation that supports this status.

Date of Birth: _____

Alien Number:_____ I-94 Number: _____

(**If you checked number 2, 3, or 4 you must attach a copy of your immigration documents**. See instruction sheet for a list of accepted immigration documents.)

Section B: ATTESTATION.

I understand that in accordance with section 8-29-10 of the South Carolina Code of Laws, a person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall, in addition to other sanctions imposed by this State or the United States, be guilty of a felony, and upon conviction must be fined and/or imprisoned for not more than 5 years (or both).

I understand that the representations made in this Affidavit shall apply through any license(s) or renewals issued, and that I shall have an affirmative duty to immediately advise the Department of Labor, Licensing and Regulation of any change of my immigration or citizenship status.

I swear and attest the information contained herein is true and correct to the best of my knowledge. I understand that under South Carolina law, providing false information is grounds for denial, suspension, or revocation of a license, certificate, registration or permit.

_____
Signature of Affiant

SWORN to before me this_____day of_____, 20_____

_____
Notary Signature

_____
Print Name

Notary Public for _____

My Commission Expires: _____

Rev: 02-02-2015

INSTRUCTION SHEET FOR COMPLETING AFFIDAVIT OF ELIGIBILITY

CHECK box 1:
If you are a United States Citizen by birth or naturalization

CHECK box 2:
If you are a Legal Permanent Resident and you are not a U.S. Citizen, but are residing in the U.S. under legally recognized and lawfully recorded permanent residence as an immigrant.
PROVIDE A COPY OF ALL IMMIGRATION DOCUMENTS.

CHECK box 3:
If you are a Qualified Alien. You are a Qualified Alien if you are:
An alien who is lawfully admitted for residence under the INA.
An alien who is granted asylum under Section 208 of the INA.
A refugee who is admitted to the United States under Section 207 of the INA.
An alien who is paroled into the United States under Section 212(d)(5) of the INA for a period of at least 1 year.
An alien whose deportation is being withheld under Section 243(h) of the INA (as in effect prior to April 1, 1997) or whose removal has been withheld under Section 241(b)(3).
An alien who is granted conditional entry pursuant to Section 203(a)(7) of the INA as in effect prior to April 1, 1980.
An alien who is a Cuban/Haitian Entrant as defined by Section 501(e) of the Refugee Education Assistance Act of 1980.
An alien who has been battered or subjected to extreme cruelty, or whose child or parent has been battered or subject to extreme cruelty.
PROVIDE A COPY OF ALL IMMIGRATION DOCUMENTS.

ACCEPTED IMMIGRATION DOCUMENTS:
Unexpired Reentry Permit (I-327)
Permanent Resident Card or Alien Registration Receipt Card With Photograph (I-551)
Unexpired Refugee Travel Document (I-571)
Unexpired Employment Authorization Card Which Contains a Photograph (I-766)
Machine Readable Immigrant Visa (with Temporary I-551 Language)
Temporary I-551 Stamp (on passport or I-94)
I-94 (Arrival/Departure Record) in Unexpired Foreign Passport
I-20 (Certificate of Eligibility for Nonimmigrant, F-1, Student Status)
DS2019 (Certificate of Eligibility for Exchange Visitor, J-1, Status)

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MEDICAL HISTORY FORM

APPLICANT: Fill this form out then take to physician's office to have completed. This form must be sent in by the doctor's office; otherwise it will not be accepted.

Name: _____ Date of Birth: _____ Social Security: xxx-xx-_____

1. Are you taking any medications? Yes No What Kind? _____
2. Are you allergic to any medication? Yes No What Kind? _____
3. You must submit an original or certified laboratory report which indicates your name and is dated no later than one year prior to South Carolina event or exhibition. The report must indicate that you are HIV, Hepatitis B and C negative. (Wrestlers are excluded from this requirement)
4. Have you ever had any of the following? (Circle answer/answer all questions)

a.	Allergies	yes	no	l.	Heart Trouble	yes	no
b.	Asthma	yes	no	m.	Hernia	yes	no
c.	Bleeding Tendencies	yes	no	n.	Tuberculosis	yes	no
d.	Chronic Cough	yes	no	o.	Kidney Trouble	yes	no
e.	Dizzy or Fainting Spells	yes	no	p.	Rheumatic Fever	yes	no
f.	Diabetes	yes	no	q.	Shortness of Breath	yes	no
g.	Eye trouble	yes	no	r.	Skin Disease	yes	no
h.	Headaches	yes	no	s.	Chest Pain	yes	no
i.	Seizures	yes	no	t.	Psychiatric Problems	yes	no
j.	Hepatitis	yes	no	u.	Surgery	yes	no
k.	Neck Injuries	yes	no	v.	Spinal Injuries	yes	no

5. If yes to any of the above, please explain: _____
_____
6. Have you ever been unconscious? Yes No If Yes, when? _____
7. Have you ever sustained any neck, spinal or other injury or have any other information concerning your health, past or present, which is not covered by the previous questions? Yes No If yes, please explain and list the physician diagnosis and treatment. _____
_____
8. Have you had any injuries while training for this bout? Yes No
9. Have you consulted any doctor while training for this bout? Yes No Whom: _____
What treatment have you received? _____
10. Do you have personal medical and hospital insurance coverage? Yes No
Effective Date: _____ Company: _____

_____ _____
Applicant's Signature Date

PHYSICAL EXAMINATION
TO BE COMPLETED BY A MD OR DO ONLY

Doctor's Office should mail or fax both forms to our office. Please see page 1 for address or fax number.

Patient Name: _____ Date of Birth: _____ Social Security: **xxx-xx-** _____

Pulse: _____ Resp: _____ Height: _____ Weight: _____ BP: _____

Vision (Snellen Chart) **Corrected**: R eye: _____ L eye: _____ **Uncorrected**: R eye: _____ L eye: _____

VISUAL FIELDS	**N**	**X**
PERIORBITAL AREA		
Recent Scars	N	X
Tenderness	N	X
Contusions	N	X
HENT		
Drums	N	X
Nasopharnynx	N	X
Adenopathy	N	X
Cranial Nerves	N	X
Hearing	N	X
Nasal Airway	N	X
CHEST		
Chest X-Ray (if required)	N	X
Lungs	N	X
Heart	N	X
ABDOMEN		
Liver	N	X
Spleen	N	X
Hernia	N	X

NEUROLOGICAL		
EKG (if required)	N	X
EEG (if required)	N	X
MRI (if required)	N	X
CAT (if required)	N	X
GaitN	N	X
Romberg	N	X
Finger to Nose	N	X
Knee Jerk	N	X
Bicep Jerk	N	X
Babiniski	N	X
ORTHOPEDIC		
Flexibility	N	X
Other	N	X
HANDS		
Tenderness	N	X
Swelling	N	X
Deformity	N	X

Does applicant/licensee appear to be under the influence of any substance to include alcohol or drugs? (Circle One)

YES NO NOT SURE

Conditions which would disqualify the applicant/licensee from this license: _____

Physician Comments: _____

After completing the above physical examination and test results (Circle One):

I DO / I DO NOT feel the applicant/licensee is physically eligible to be licensed as a fighter.

_____ _____ _____

Signature of Examining Physician MD or DO License Number Date

_____ _____

Print or Stamp Name of MD or Do Phone Number (XXX) XXX-XXXX

_____ _____

Office Street Address, City, State, Zip Fax Number (XXX) XXX-XXXX

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OPHTHALMIC HISTORY FORM

(WRESTLERS ARE EXEMPT FROM THIS FORM)

APPLICANT: Fill this form out then take to the optometrist's office to have completed. This form must be sent in by the optometrist's office; otherwise it will not be accepted.

Name: _____

Date of Birth: _____ Age: _____ Social Security (Last 4 digits only): xx-xxx-_____

Boxing History:

How many fights have you had	Dates From - To	Total	Won	Lost	(T) K.O.'d
Amateur					
Professional					
Date of last KO					

Any eye injuries: YES / NO Any eye meds:YES / NO If yes list type(s): _____

_____

Have you has any eye diseases or surgery? YES / NO If yes, explain: _____

_____

Have you ever had any retina surgery or laser treatment of the eye? YES / NO If yes, explain: _____

_____

Have you ever had refractive or laser correction to your vision? YES / NO If yes, explain: _____

_____

Name(s) and Address of any physicians who have treated your eyes: _____

_____

_____

ATTESTATION:

I certify (or declare) under penalty of perjury, that the foregoing history is true and correct. Should I furnish any false or incomplete information, I hereby agree that such act shall constitute the cause for denial, revocation or disciplinary action to my license in the State of South Carolina.

_____ _____

Applicant's Signature Date

EYE EXAMINATION

Optometry Office should mail or fax both forms to our office. Please see page 1 for address or fax number.

Patient's Name: _____ Date of Birth: _____ Social Security: xx-xxx-_____
(Last 4 digits only)

Ophthalmic Exam

	Right Eye	Left Eye
Vision with naked eye		
Vision with corrective lenses		
Abnormalities in:		
Conjunctiva or Eyelids		
Eye Muscles or Strabismus		
Cornea; lenses		
Anterior Chamber, Chamber Angle (include Gonioscopy)		
Vitreous		
Peripheral Retina		
Macula		
Optic Nerve		
Visual Field (Goldman III 4e or equivalent)		
Eye Pressure, mm.Hg. (list test)		

Optometrist's remarks on abnormal findings: _____

_____

_____

_____

Conditions which would disqualify the applicant/licensee from this license: _____

_____

After completing the above eye examination and test results (Circle One):

I certify that as a result of this examination, **I DO / I DO NOT** feel the applicant/licensee is eligible to be licensed.

_____ _____ _____
Signature of Ophthalmologist or Optometrist | Doctor's License Number | Date

_____ _____
Print or Stamp Name of Ophthalmologist or Optometrist | Phone Number (XXX) XXX-XXXX

_____ _____
Office Street Address, City, State, Zip | Fax Number (XXX) XXX-XXXX

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MEDICAL INFORMATION RELEASE

This form gives the South Carolina Athletic Commission, hereinafter known as SCAC, authorization to distribute medical information to all member commissions affiliated with the Association of Boxing Commissions, hereinafter known as ABC.

I hereby authorize the SCAC to release, disclose and furnish any other commission or program affiliated with the ABC, any and all of my medical records obtained by the SCAC concerning my licensure as a combative sport contestant. This information may consist of, but is not limited to, annual physical examinations, ophthalmologic examinations, neurological examinations, negative test for HIV virus, Hepatitis B virus, and Hepatitis C virus, drug testing, hospital records and any other information regarding conditions related to the propriety of my licensure as a combative sport contestant (including history, findings, diagnosis and prognosis).

I understand, and it is agreed, that the signing of this Medical Information Release is optional and that my declining to sign this document will not result in any adverse action being taken against me by the SCAC or any of the member commission affiliated with the ABC.

I understand, and it is agreed, that the medical records described herein will not be released for any purpose other than the purpose of a member commission affiliated with the ABC to determine my eligibility to participate in a boxing, wrestling or MMA contest.

I understand, and it is agreed, that this authorization shall remain in effect for a period of one year from the date it is signed and is relevant to all medical records described herein whether such records were created prior to or subsequent to the date of the authorization signed.

Signature of Combative Contestant	Boxer Federal ID# or MMA Contestant's National ID#
Print Name of Combative Contestant	Date Signed
Signature of SCAC Representative	Date Signed