



TEXAS DEPARTMENT OF LICENSING AND REGULATION
PO Box 12157 • Austin, Texas 78711-2157
(800) 803-9202 • (512) 463-5101 • FAX (512) 463-1087
www.tdlr.texas.gov • Combative.Sports@tdlr.texas.gov

COMBATIVE SPORTS PROFESSIONAL CONTESTANT LICENSE APPLICATION INSTRUCTIONS

The application must be completed and signed by the applicant. An application is not considered complete and will not be processed until all required items have been submitted. All information provided must be typed or printed in black ink. Attachments must be submitted on separate pieces of single-sided, 8½" x 11" paper. Use a paperclip to fasten all pages together, with a cashier's check or money order on top. **Do not use staples.** Make cashier's check or money order payable to TDLR.

DOCUMENTS SUBMITTED WITH YOUR APPLICATION WILL NOT BE RETURNED. KEEP A COPY OF YOUR COMPLETED APPLICATION, ALL ATTACHMENTS, AND YOUR CASHIER'S CHECK OR MONEY ORDER.

1. NAME - Write your legal name in the spaces provided. (Last, First, Middle Name, Suffix) Examples of a suffix include Jr., Sr., and III. (Mr. is not a suffix.)
2. DATE OF BIRTH - Write your birthdate. Minors age 17 but not yet 18 may be issued a contestant's license with a notarized written consent from a parent or guardian.
3. PLACE OF BIRTH - Write the city and state of your place of birth.
4. GENDER - Select whether you are male or female.
5. SOCIAL SECURITY NUMBER - Write your social security number. Social security number disclosure is required by Section 231.302(1) of the Texas Family Code in order to obtain a license. Your social security number is subject to disclosure to an agency authorized to assist in the collection of child support payments. For more information regarding child support payments, contact the Texas Attorney General at:
www.oag.state.tx.us/child/index or call (512) 460-6000 or (800) 252-8014
6. FOREIGN NATIONAL PASSPORT NUMBER - Applicants who are foreign nationals, must provide their passport number.
7. MAILING ADDRESS - Write your current mailing address. This is the address where we will send you mail. This address can be a post office box. You can use the zip plus-4 to help the postal service deliver mail more efficiently and accurately.
8. EMAIL ADDRESS - Write your email address. Please provide your email address so the department may email license information and required notices to you. Your email address is confidential pursuant to the Texas Public Information Act, and the department will not share it with the public.
9. PHONE NUMBER - Write a telephone number, including the area code, where we can reach you during the day. This may be your office phone number where we can leave a message.
10. EVENT DATE - Write the date of the combative sports event you are participating in.
11. PROMOTER NAME - Write the name of the promoter of the combative sports event.
12. APPLICANT CONSENT TO RELEASE - Carefully read the consent to release before you date and sign your application.

PROFESSIONAL CONTESTANT'S MEDICAL EXAMINATION - Proof of having passed a comprehensive medical examination must be within the last six months. Parts one and two must be completed by a medical doctor licensed by a state, district or territory of the United States of America. Forms completed by a physician's assistant or nurse practitioner will not be accepted.

OPHTHALMOLOGIC MEDICAL EXAMINATION - Proof of having passed an ophthalmologic medical examination must be within the last six months. This exam must be completed by an ophthalmologist or optometrist licensed by a state, district or territory of the United States of America.

APPLICATION INFORMATION FOR MILITARY SERVICE MEMBERS, MILITARY VETERANS AND MILITARY SPOUSES

The Texas Department of Licensing and Regulation recognizes the contributions of our active duty military service members, their spouses, and veterans. If you want to use one of the licensing options available to military service members, military veterans and military spouses, please complete the **Military Service Member, Military Veteran or Military Spouse Supplemental Application (TDLR form MIL001)** and attach it with your license application. The form is located on the TDLR website at: <http://www.tdlr.texas.gov/misc/militarysupplemental.pdf>.

If you have additional questions about qualifications, training or experience requirements relating to occupation licensing for military service members, military veterans or military spouses please go to the TDLR Military Information web page at: <http://www.tdlr.texas.gov/military.htm>.

State law prohibits renewing a license more than once after a licensee has defaulted on a student loan guaranteed by the **Texas Guaranteed Student Loan Corporation (TGSLC)** unless the licensee has entered into a repayment agreement with TGSLC. **YOU SHOULD CONTACT TGSLC BEFORE FILING THIS APPLICATION** if you have defaulted on a student loan. An application or renewal may be rejected if this agency has received information from TGSLC that the applicant has defaulted on a student loan. The Texas Guaranteed Student Loan Corporation can be contacted at: **Texas Guaranteed ATTN: Collections, PO Box 83100, Round Rock, TX 78683-3100, Telephone: (800) 222-6297, <http://www.tgslc.org> or email: cust.assist@tgslc.org.**

Applicant Name:

Last

First

Middle Name

Suffix

PROFESSIONAL CONTESTANT'S MEDICAL EXAMINATION - PART 1

TO BE COMPLETED BY A LICENSED MEDICAL DOCTOR ONLY

Forms completed by a physician assistant or nurse practitioner will NOT be accepted

Medical Allergies: _____

Are you taking any medication: Yes No if YES Explain: _____

Previous Hospitalization(s) or Surgery (provide dates): _____

Results of the following blood tests must be attached to this application:

- Hepatitis B surface ANTIGEN
- Hepatitis C ANTIBODY
- HIV ANTIBODY

ALL MEDICAL AND LAB TEST RESULTS MUST BE DATED AND TAKEN WITHIN THE LAST SIX MONTHS BEFORE THE APPLICATION IS SUBMITTED

All Sections Must Be Completed (circle each answer)

- | | | | | | |
|---------------------------------|-----|----|--|-------|-------|
| (A) BLEEDING TENDENCIES | YES | NO | (N) HIGH BLOOD PRESSURE | YES | NO |
| (B) DIABETES | YES | NO | (O) TUBERCULOSIS | YES | NO |
| (C) HERNIA | YES | NO | (P) MONONUCLEOSIS | YES | NO |
| (D) HEART DISEASE | YES | NO | (Q) RHEUMATIC FEVER | YES | NO |
| (E) SICKLE CELL DISEASE | YES | NO | (R) COUGH | YES | NO |
| (F) KIDNEY DISEASE | YES | NO | (S) PSYCHIATRIC PROBLEMS | YES | NO |
| (G) HEPATITIS | YES | NO | (T) CONTACT LENSES | YES | NO |
| (H) SKIN DISEASE | YES | NO | (U) NUMBER OF TIMES KO'D | _____ | _____ |
| (I) HEADACHES | YES | NO | (V) KIDNEY, LUNG, TESTICLE, EYE REMOVED | YES | NO |
| (J) JOINT INJURY OR DISLOCATION | YES | NO | (W) ABDOMEN (any scars) | YES | NO |
| (K) CONCUSSION/UNCONSCIOUSNESS | YES | NO | (X) LIVER, KIDNEY, SPLEEN (enlarged, tender) | YES | NO |
| (L) SEIZURES AND CONVULSIONS | YES | NO | (Y) INGUINAL AREA (tenderness, hernia) | YES | NO |
| (M) ASTHMA | YES | NO | | | |

Do you have any other information concerning your health, past or present, which is NOT COVERED by the questions above? _____

A PERSON AGE 36 OR OLDER MUST ALSO SUBMIT A FAVORABLE:

- EEG (Electroencephalography) AND
- EKG (Electrocardiogram)

Applicant Name:

Last

First

Middle Name

Suffix

PROFESSIONAL CONTESTANT'S MEDICAL EXAMINATION - PART 2

EARS

AUDITORY CANALS

RIGHT _____ LEFT _____

DRUMS

RIGHT _____ LEFT _____

AUDITORY ACUITY FOR CONVERSATIONAL VOICE

RIGHT _____ LEFT _____

NOSE (deformity, old fractures, deviated septum, other) _____

OROPHARYNX

TONSILS _____ GUM _____ TEETH _____

TONGUE (record any deviation or tremors) _____

NECK (masses, pulse, thyroid, carotid, bruits, and limitation of motion) _____

THORAX

LUNGS _____

HEART (size, murmurs, arrhythmia) _____

* Provide numerical values

*HEART RATE _____ *BLOOD PRESSURE (S) _____ *(D) _____

*PULSE RATE _____ *IMMEDIATELY AFTER 20 HOPS _____

*2 MINUTES AFTER EXERCISE _____

SKIN (staph infection, cyanosis, hair distribution) _____

LYMPHATIC SYSTEM _____

MUSCULOSKELETAL SPINAL SYSTEM
(curvature, posture, tenderness, limitation of motion) _____

EXTREMITIES (deformity, tenderness, joint mobility) _____

NEUROLOGICAL

GAIT _____ RHOMBERG _____

FINGER TO NOSE _____ KNEE JERKS _____

BICEP JERKS _____ BABINSKI _____

BRUDZINSKI _____ CRANIAL NERVES _____

I HAVE APPROVED THIS PERSON TO PARTICIPATE IN A COMBATIVE SPORTS EVENT

MD or DO NAME: (Print) _____

LICENSE NUMBER: _____
(must be licensed in a state, district, or territory of the United States)

ADDRESS _____ CITY _____

STATE _____ ZIP CODE _____ PHONE NUMBER (_____) _____

MD or DO SIGNATURE _____ DATE _____

APPLICANT SIGNATURE _____ DATE _____

Applicant Name:

_____ Last _____ First _____ Middle Name _____ Suffix _____

**** OPHTHALMOLOGIC MEDICAL EXAM ****

Exam with dilation must be done by an OPHTHALMOLOGIST or OPTOMETRIST

All Sections Must Be Completed

	RIGHT EYE	LEFT EYE
VISUAL ACUITY MEASUREMENT WITHOUT CORRECTION	N _____	N _____
	F _____	F _____
EXTERIOR EXAM	_____	_____
ANTERIOR EXAM	_____	_____
FUNDI	_____	_____
EXTRAOCULAR MUSCLES	_____	_____
VISUAL FIELDS (confrontation)	_____	_____
TONOMETRY MEASUREMENTS	_____	_____

EXPLAIN ABNORMAL FINDINGS _____

DIAGNOSIS _____

I hereby certify that a dilated exam was performed on _____
Print applicant's name

Date of the exam: _____ - _____ - _____
Month Day Year

I HAVE APPROVED THIS PERSON TO PARTICIPATE IN A COMBATIVE SPORTS EVENT

OPHTHALMOLOGIST or OPTOMETRIST NAME: (Print) _____

LICENSE NUMBER: _____
(must be licensed in a state, district, or territory of the United States)

ADDRESS _____ CITY _____

STATE _____ ZIP CODE _____ PHONE NUMBER (_____) _____

OPHTHALMOLOGIST or OPTOMETRIST SIGNATURE _____ DATE _____

APPLICANT SIGNATURE _____ DATE _____