AMATEUR MMA MEDICAL CERTIFICATE

Each Amateur MMA athlete shall undergo a medical examination in their own country, **one week** before the competition start date. A UWW Medical Certificate should be completed and signed by an official medical doctor appointed by the National Federation. This form must be delivered to the UWW doctor of the competition at the pre-weighing medical examination.

UWW AMATEUR MMA EVENT

Competition: .....

Place: .....

Date: .....

ATHLETE

Surname: ..... First Name: .....

Date of Birth (Day/Month/Year): …. /…. /….

Sex: ☐ Male ☐ Female

Weight Class: .....

Nationality: .....

Address: .....

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E-mail: .....

Phone Number: .....

MEDICAL ASSESSMENT SUMMARIES

1. General Examination:

A- Medical History:

- Any hospital admissions, serious injury or illness (physical or mental), allergies, and chronic conditions, and if under specialist care currently
- Any history of severe eye trauma, head trauma or concussion
- Any surgical procedures carried out
- Any family history of sudden cardiac death, dementia or Parkinsonism

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B- Lab Tests:

Routine - Complete blood count (CBC). **Serology -** HEP B (HBsAg), HEP C (Anti-HCV), HIV (Ag/Ab)

☐ Normal ☐ Abnormal - Please specify:

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C- Skin Inspection:

Any skin infection, lesion, wound or laceration

☐ Normal ☐ Abnormal - Please specify:

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D- General Health:

☐ Normal ☐ Abnormal - Please specify:

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Examining Doctor:

Surname & Name: ..... Date: .....

Address: .....

Signature:

2. Cardiorespiratory Examination

Physical examination, Chest x-ray, Heart rate & rhythm, Blood pressure, Electrocardiography

☐ Normal ☐ Eligible to compete with considerations ☐ Non-eligible to compete

Please specify: .....

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Examining Doctor:

Surname & Name: ..... Date: .....

Address: .....

Signature:

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3. Neurological Examination

Muscle weakness? Coordination? Tremor? Romberg? Cognitive impairment? Nystagmus? Headache? Recent concussion

☐ Normal ☐ Eligible to compete with considerations ☐ Non-eligible to compete

Please specify: .....

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Examining Doctor:

Surname & Name: ..... Date: .....

Address: .....

Signature:

4. Ophthalmologic Examination

A dilated eye exam must be administered by a licensed ophthalmologist or optometrist

☐ Normal ☐ Eligible to compete with considerations ☐ Non-eligible to compete

Please specify: .....

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Examining Doctor:

Surname & Name: ..... Date: .....

Address: .....

Signature:

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5. Orthopedic Examination

A dilated exam on spine (cervical, thoracic, lumbar), Shoulder, Arm, Elbow, Forearm, Wrist, Hand, Fingers, Hip, Thigh, Knee, Lower leg, Ankle and Foot

☐ Normal ☐ Eligible to compete with considerations ☐ Non-eligible to compete

Please specify: .....

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Examining Doctor:

Surname & Name: ..... Date: .....

Address: .....

Signature:

AMATEUR MMA MEDICAL CERTIFICATE

Medical Certification

I certify that this athlete:

☐ Has no apparent contraindication to practicing Amateur MMA at a competitive level.

☐ Is not recommended to practice Amateur MMA at a competitive level.

☐ Normal ☐ Eligible to compete with considerations ☐ Non-eligible to compete

Please specify:

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Certifying Doctor:

Surname & Name: ..... Date: .....

Medical Registration Number: .....

Address: .....

Phone Number: ..... Fax Number: .....

E-mail: .....

Signature & Stamp:

UWW Doctor Approval

☐ The Medical Certificate is approved.

☐ The Medical Certificate is not approved.

Surname & Name: ..... Date: .....

Signature: