



South Carolina Department of Labor, Licensing and Regulation

## South Carolina Athletic Commission

P.O. Box 11329 • Columbia, SC 29211  
Phone: 803-896-4571 • Fax: 803-896-4350  
Contact.Athl@llr.sc.gov  
[www.llr.state.sc.us/POL/Athletic/](http://www.llr.state.sc.us/POL/Athletic/)



### 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.



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### APPLICATION FOR LICENSURE

**\*\*All licenses are valid through December 31<sup>st</sup> of application year; regardless of application date\*\***

Select the type of license you are applying for and remit application fee via check or money order only.

A returned check fee of up to \$30, or an amount specified by law, may be assessed on all returned funds.

- \$50 Boxer
- \$50 Kick Boxer
- \$50 Amateur MMA
- \$50 Off the Street Boxer
- \$50 Wrestler
- \$50 Pro MMA

<b>FOR COMMISSION USE ONLY</b>	
State Lic #	_____
Federal ID #	_____
Weight	_____

#### APPLICANT INFORMATION:

Full Name: \_\_\_\_\_

Professional Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

(Street, City, State & Zip Code)

Mailing Address: \_\_\_\_\_

(If different than above)

Telephone: (Cell) \_\_\_\_\_ (Other) \_\_\_\_\_

Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security: \_\_\_\_\_

**Attach a valid photo ID that verifies your date of birth. (Driver's license, State ID or Passport)**

#### PERSONAL HISTORY

1. Are you presently licensed or have you ever been licensed by any state or local athletic commission? Yes      No  
If yes, please list state(s): \_\_\_\_\_
  
2. Have you ever been denied any type of professional or occupational license, including athletic license or permit in this state or jurisdiction? Yes      No  
(If yes, provide a detailed explanation on a separate sheet and remit with application.)
  
3. Have you ever had any type of professional or occupational license or permit suspended, revoked, surrendered or have you ever been disciplined by the licensing authorities in this state or any other state or international jurisdiction? (If yes, provide a detailed explanation on a separate sheet and remit with application.) Yes      No

**(Wrestlers Excluded from this section)**

4. Do you have an Amateur or Professional Fight Record or Pass Book? Yes  No

If yes, please list state(s): \_\_\_\_\_

Manager's Name (If Applicable): \_\_\_\_\_

Date of Last Event: \_\_\_\_\_ Location: \_\_\_\_\_

How many fights have you had	Total	Won	Lost	Draw	(T) K.O.'d
Amateur					
Professional					
Elimination Matches, Tough Man, Off the Street					

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**Privacy Act Disclosure:**

*South Carolina Law requires that every individual who applies for an occupational or professional license provide a social security number for use in the establishment, enforcement and collection of child support obligations and for reporting to certain databanks established by law. Failure to provide your social security number for these mandatory purposes will result in the denial of your licensure application. Social security numbers may also be disclosed to other governmental regulatory agencies and for identification purposes to testing providers and organizations involved in professional regulation. Your social security number will not be released for any other purpose not provided for by law.*

Other personal information collected by the Department for the licensing boards it administers is limited to such personal information as is necessary to fulfill a legitimate public purpose. The South Carolina Freedom of Information Act ensures that the public has a right to access appropriate records and information possessed by a government agency. Therefore, some personal information on the application may be subject to public scrutiny or release. The Department collects and disseminates personal information in compliance with The South Carolina Freedom of Information Act, the South Carolina Family Privacy Protection Act, and other applicable privacy laws and regulations. Additionally, the Department shares certain information on the application with other governmental agencies for various governmental purposes, including research and statistical services.

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**ATTESTATION AND SIGNATURE**

I, \_\_\_\_\_, am the person described and identified, of good moral character, and  
(Print Name)

the person named in all documents presented in support of this application. I certify that I have never been convicted of violating any Federal, State, Municipal or other law statute or ordinance, other than as disclosed as required within this application.

I certify that all statements contained herein are true and correct to the best of my knowledge. I further understand that false or incorrect information provided by me may result in the cancellation of any license issued pursuant to this application.

\_\_\_\_\_  
**Signature of Applicant**

\_\_\_\_\_  
**Date**



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: \_\_\_\_\_

## 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)



### 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: \_\_\_\_\_

<b>VISUAL FIELDS</b>	N	X	<b>NEUROLOGICAL</b>		
<b>PERIORBITAL AREA</b>			EKG (if required)	N	X
Recent Scars	N	X	EEG (if required)	N	X
Tenderness	N	X	MRI (if required)	N	X
Contusions	N	X	CAT (if required)	N	X
<b>HENT</b>			GaitN	N	X
Drums	N	X	Romberg	N	X
Nasopharynx	N	X	Finger to Nose	N	X
Adenopathy	N	X	Knee Jerk	N	X
Cranial Nerves	N	X	Bicep Jerk	N	X
Hearing	N	X	Babiniski	N	X
Nasal Airway	N	X	<b>ORTHOPEDIC</b>		
<b>CHEST</b>			Flexibility	N	X
Chest X-Ray (if required)	N	X	Other	N	X
Lungs	N	X	<b>HANDS</b>		
Heart	N	X	Tenderness	N	X
<b>ABDOMEN</b>			Swelling	N	X
Liver	N	X	Deformity	N	X
Spleen	N	X			
Hernia	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**

	<b>Right Eye</b>	<b>Left Eye</b>
Vision with naked eye	_____	_____
Vision with corrective lenses	_____	_____
<b>Abnormalities in:</b>		
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 medial 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