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(c)(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. By providing my email address I authorize TDLR to send licensing communications and required notices to me by electronic mail. I understand that I may revoke this authorization in writing and that I must update my email address or I will not receive these notices. I understand that the email address I have provided in this application will remain confidential except as permitted or required by law.
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.**

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COMBATIVE SPORTS PROFESSIONAL CONTESTANT LICENSE APPLICATION

Do Not Write Above This Line

YOU MUST MEET ALL REQUIREMENTS WITHIN 12 MONTHS OF THE FILING DATE, OR THE APPLICATION WILL BE TERMINATED.

APPLICATION FEE: $20 (FEE IS NON-REFUNDABLE)

1. Name:

_____ _____ _____ _____
Last First Middle Name Suffix (JR, SR, III)

2. Date of Birth:

_____ - _____ - _____
Month Day Year

3. Place of Birth: (City and State)

_____

4. Gender:

☐ **Male** ☐ **Female**

5. Social Security Number:
(See instruction sheet for disclosure information)

_____ _____ _____ _____ _____ _____ _____ _____ _____

6. Foreign National Passport Number: (Foreign nationals must provide their passport number)

_____

7. Mailing Address: (A PO box is allowed for this address)

Number, Street Name, Suite Number/Apartment Number

City State Zip Code

8. Email Address:

_____
(Ex: johndoe@aol.com) See instruction sheet for disclosure information

9. Phone Number:

(_____) _____
Area Code Phone Number

10. Event Date:

_____ - _____ - _____
Month Day Year

11. Promoter Name:

_____

12. APPLICANT CONSENT TO RELEASE

I declare under penalty of perjury under the laws of the State of Texas that the foregoing information is true and correct, further I realize that any intentional misrepresentation may result in disciplinary action against my license. I hereby AUTHORIZE the Texas Department of Licensing and Regulation (Department), pursuant to the provisions of Texas Administrative Code, Chapter 61, §61.47(s), to RELEASE any and all medical information and/or personal information with respect to my status and licensure as a contestant which may be contained in any of the Department's records. I further authorize the Department to release this information to any person whom the Department determines has a need to know. I agree that I will fully cooperate with the Department in making my medical history available including but not limited to, giving oral or written reports to the Department regarding my medical condition, care and/or treatment. I further RELEASE, PROMISE TO HOLD HARMLESS, and COVENANT NOT TO SUE the Department on the basis of its attempts to obtain any of the foregoing information, and I further RELEASE, PROMISE TO HOLD HARMLESS, and COVENANT NOT TO SUE any persons, firms, institutions or agencies providing such information to representatives of the Department on the basis of its disclosures. I have signed this Release voluntarily And of my own free will. I further agree that a photographic copy of this Authorization shall be valid as the original.

_____ _____
Date Signed Applicant Signature

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 MEASURMENT 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** _____