Malta Boxing Association

MBA Office: 5, Camelia Street,
Hamrun. Malta. HMR1700
Email: maltaboxingsec@gmail.com
www.maltaboxingassociation.org

APPLICATION FOR A PROFESSIONAL BOXING LICENSE – FOREIGN NATIONAL

DATE		**MBA No.**	
APPLICANT'S SURNAME			
APPLICANT'S FIRST NAME			
ADDRESS			
PASSPORT No.: (A photocopy of the passport must be submitted with this form)			
NATIONALITY:		**DATE OF BIRTH:**	
EMAIL:		**TEL.No.:**	
OCCUPATION:		**WEIGHT:**	
APPLICANT'S SIGNATURE:			

FEES: (Payment must be sent with this form, otherwise the application will NOT be processed)

PRO LICENCE: €175.00 PER YEAR. (1st January- 31st December). Insurance is strongly recommended and this should be taken care of by the applicant.

Fee must be paid either by cash, Local (Maltese) cheque or by Bank Transfer.
Account No.: 4002481597-2 - Bank's BIC: VALLMTMT -
IBAN: MT45 VALL 2201 3000 0000 4002 4815 972 - Account Name: Michael Bonello MBA

MEDICAL REQUIREMENTS: All Tests are valid for 12 months. CERTIFICATES TO BE ATTACHED WITH THIS APPLICATION. Photos of certificates ARE NOT accepted. Application will not be processed if any certificates are missing:

MRI	**EYE TEST**	**BLOODTESTS: HEPATITIS B & C**	**HIV**	**MBA MEDICAL EXAMINATION FORM**

FOR MBA OFFICIAL USE ONLY:

Documents Received:	PASSPORT	MRI	EYE TEST	BLOODTESTS	HIV	MEDICAL EXAMINATION FORM

DATE RECEIVED:		PAYMENT RECEIVED BY:	CASH	BANK
MBA OFFICIAL SIGNATURE				

Boxers are to abide by the Rules & Regulations of the Malta Boxing Association as laid down in the Statute which can be accessed and downloaded at: https://www.maltaboxingassociation.org/rules--regulations.html
Boxers are also to note and be aware of the NADO Malta Anti-Doping Regulations which can be viewed at NADO Malta's website at: http://nadomalta.org/wp-content/uploads/2016/05/WADA_Prohibited_List_2017_EN.pdf

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BOXERS MEDICAL EXAMINATION FORM

(To be completed by a certified medical doctor at time of application and annually when license fee due)

Note to Applicant:

This examination must be carried out by a Qualified Medical Practitioner, currently on the Medical Register.

Note to Examining Doctor:

This form, when completed, should be forwarded to the Malta Boxing Association. Representative or to the above address. The Fee for the examination is payable by the Boxer.

QUESTIONS TO BE ASKED BY AN EXAMINING DOCTOR

Full Personal Name____(Block Letters)

Professional Boxing Name (If different from above)________________________(Block Letters)

Address____(Block Letters)

Date of Birth ____________________ Marital Status ______________________

Tel. No. ________________________ Mobile No. _________________________

Occupation (Other than Boxer) ____

Manager or proposed Manager____

Have you held a license previously _______________________________________

If so, give past record of contests:

No. _________ Won ________ Lost ________ Counted Out ________ Stopped ________

Amateur/unlicensed record if any ____

____

1. Are you in good health as far as you know______________________________
2. Have you suffered at any time any serious illness, injury, accident or disability. if so give details

____

3. Have you suffered at any time from any of the following (If so give full details – Doctors consulted and results of investigations).

Headaches, blackouts or fits ____

Anxiety states or depressions ____

Paralysis or any other mental or nervous diseases ___________________________

Have you seen a psychiatrist or taken tranquillisers __________________________

4. Visual disturbances, such as diplopia, blurring vision, or do you wear glasses or contact lenses

____

5. Any ear discharge, deafness, etc. ____

6. Heart disease, high blood pressure, heart murmurs, varicose veins, rheumatic or scarlet fever

____

7. Any asthma, bronchitis, pneumonia, or T.B, sinusitis or any difficulty in nasal breathing ______

8. Any chronic indigestion, stomach or duodenal ulcers, gall bladder or liver disease, appendicitis, hernia, bowel disorders, Crohn's Disease, haemorrhoids etc. ___________________________

9. Any kidney or bladder problems, diabetes, renal colic, haematuria, venereal infections or prostatitis ____

10. Any bone or joint problems, e.g. hand injuries, fractures, etc. ___________________________

11. Any skin diseases ______________________ Allergies _______________________________

12. Are you or have you been attending your doctor or hospital regularly for any reason _________

13. Do you take tablets/medicines, etc, regularly _______________________________________

14. Date and result of last X-ray (if any) ____

15. Any other investigations, i.e. blood tests, X-rays, E.C.G., E.E.G. ________________________

Number of cigarettes smoked per day ____

Daily alcohol intake ____

Family History

Father (age and health) _______________________ Mother (age and health) ____________________

Brothers (age and health) _____________________ Sisters (age and health) ____________________

I hereby give my consent to the Malta Boxing Association and it's Medical Officers to contact my doctor to obtain

medical information pertaining to my application to box.

Signature of Boxer ____

Signature of Doctor ____

Doctor's official stamp:

EXAMINATION

Height ____________________________________ Weight _________________________________

Describe build, etc. If overweight, is excess evenly distributed _________________________________

____

If he/she has had a MRI/MRA Brain Scan, indicate date. _____________________________________

Pulse _____________________________ Apex beat _______________________________________

Blood pressure (if above 140/90 please record 3 further readings at 5 minute intervals) _____________

Heart sounds ____

Any murmurs ____

If so describe ____

Any varicose veins _____________________ Exercise tolerance ______________________________

Respiratory System

Chest movements ___________________________ Trachea ________________________________

Percussion Notes ________ Air Entry ________ Breath Sounds ________ Added Sounds __________

Abdomen

Any scars, tenderness or masses – if so, describe ____

Are liver, spleen and kidney palpable ____

Hernia orifices _______________________ Genitalia ______________ Urine ________________

Central Nervous Systems

Cranial nerves ______________________ Pupils _____________________ Optic fundi _______________

Nystagmus _____________________________ Rombergism _____________________________________

Limbs

Tone _______________ Power _____________ Co-ordination _____________ Sensation _____________

Reflexes _______________________________ Plantar responses ________________________________

Any psychoneurosis ________________ If yes, describe ____

Skeletal System

Cervical Spine ___________Shoulders ___________ Elbows ___________ Wrists and hands ___________

Lumbar Spine ____________ Hips _____________ Knees _____________ Ankles ___________________

HIV & Hepatitis Vaccination and Screening

HIV Test:- Test date _________________________________ **Forward Laboratory results to MBA**

Hepatitis C:- Test date _________________________________ **Forward Laboratory results to MBA**

Hepatitis B:- Test date _________________________________ **Forward Laboratory results to MBA**

Please note that every Boxer must complete the Hepatitis B Vaccination course, the course consists of three doses. The second dose is given one month after the first dose and the third dose is given five months after the second dose. This course must be completed and evidence of dates must be forwarded to the Malta Boxing Association.

Ears

Drum _________________________ Hearing ______________________ Any otitis __________________

NOTE TO EXAMINING DOCTOR – If any abnormality noted, please investigate further and refer all relevant documents to the Commission's Chief Medical Officer at the Head Office of the Malta Boxing Association, with this form.

Date of examination ________________________________

I AM SATISFIED AS TO THE CORRECT IDENTITY OF THE EXAMINEE, WHO HAS PRODUCED FOR ME PHOTOGRAPHIC ID SUCH AS HIS OR HER'S BOXER'S LICENCE, DRIVING LICENCE OR PASSPORT, OR ALTERNATIVELY, I CONFIRM HIS OR HER LIKENESS BY SIGNING THE ATTACHED PHOTOGRAPH.

Name of Doctor in BLOCK LETTERS: ____

Doctor's Clinic address: ____

Tel. No: _______________________________ Email: ____

Signature of examining Doctor ____

Official Stamp of Doctor:

COMMENTS (If Any):

It is important that all the above Doctor's details, i.e Name, Clinic Address, Tel. No, Email, Signature and Official stamp are clearly shown and included, otherwise this form will not be accepted by the MBA. The MBA will randomly check with examining doctors for the authenticity of this examination and/or other medical certificates presented to the MBA.

Eye Test:

Eye test to be completed by an Ophthalmic Optician/Consultant

Visual standards **(Snellen's type figures without glasses)** ______________________________

Visual fields ______________________________

Ocular tension ______________________________

Ocular movement's ______________________________

Ophthalmoscopic examination (with special attention to retinal defects) ______________________________

Date of examination ______________________________

I AM SATISFIED AS TO THE CORRECT IDENTITY OF THE EXAMINEE, WHO HAS PRODUCED FOR ME PHOTOGRAPHIC ID SUCH AS HIS OR HER'S BOXER'S LICENCE, DRIVING LICENCE OR PASSPORT, OR ALTERNATIVELY, I CONFIRM HIS OR HER LIKENESS BY SIGNING THE ATTACHED PHOTOGRAPH.

Name of Optician/Consultant in BLOCK LETTERS: ______________________________

Optician/Consultant's Clinic address: ______________________________

Tel. No: ______________________________ Email: ______________________________

Signature of Optician/Consultant ______________________________

Official Stamp of Optician/Consultant:

It is important that all the above Optician/Consultant's details, i.e Name, Clinic Address, Tel. No, Email, Signature and Official stamp are clearly shown and included, otherwise this form will not be accepted by the MBA. The MBA will randomly check with examining doctors/consultants for the authenticity of this examination and/or other medical certificates presented to the MBA.

TO BE COMPLETED BY THE MBA's CHIEF MEDICAL OFFICER (OR HIS DEPUTY)

CONFIDENTIAL

To the stewards of the Malta Boxing Association. The following recommendation is made in the case of:

Name ______________________________

(a) Licence granted or renewed ______________________________

(b) Licence not granted/renewed ______________________________

Date: ______________________________ Signature ______________________________