Malta Boxing Association

c/o 5, Camelia Street, Hamrun. HMR1700
Malta
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. (12 months from date of submission of completed form and payment). Insurance is strongly recommended, and this should be taken care of by the applicant.

Fee must be paid either by cash, Revolut to +356 99471413 or by Bank Transfer to:
Bank Name: Revolut Bank UAB - Bank's BIC/SWIFT: REVOLT21
IBAN: LT82 3250 0718 1007 2764 - Account Name: Francis Borg

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

All Medical Certificates submitted will be verified for authentication by the MBA. Please allow 10 days from the date of submitting the medicals for the License to be issued.

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 Antigen:- Test date ______________________**Forward Laboratory results to MBA**

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

Hepatitis B Surface Antibody:- 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.

All Medicals submitted will be verified by the MBA for authentication. Please allow 10 days for License to be issued from the date of submitting the medicals. Submitting false Medicals will result in serious disciplinary actions and possible legal/criminal proceedings by the authorities.

This application will be rejected if any of the above fields in this form are left blank.

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. Please allow 10 days from the date of submitting the medical certificates for the License to be issued.

This application will be rejected if any of the above fields are left blank.

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 ID CARD, DRIVING LICENCE OR PASSPORT, OR ALTERNATIVELY, I CONFIRM HIS OR HER LIKENESS BY SIGNING THE ATTACHED PHOTOGRAPH.

FURTHERMORE, I AM SATISFIED THAT THE EXAMINEE IN RELATION TO THE EYES, IS IN A FIT CONDITION AND CERTIFY THE APPLICANT IS FIT TO TRAIN AND COMPETE IN BOXING UNDER THE MALTA BOXING ASSOCIATION

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.

Medicals submitted will be verified by the MBA with the examining doctors/consultants/clinics for authentication. Please allow 10 days for License to be issued from the date of submitting the medicals, application form and payment. Submitting false Medicals will result in serious disciplinary actions and possible legal/criminal proceedings by the authorities.

This application will be rejected if any of the above fields in this form are left blank.

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) License granted or renewed: ______________________________

(b) License not granted/renewed: ______________________________

(c) Documents verification confirmed: ______________________________

Date: ______________________________ Signature ______________________________