



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
ONLY FOR FOREIGN NATIONALS RESIDING IN NON-EBU AFFILIATED COUNTRIES OR
WITH PROOF OF RESIDENCE IN MALTA (Proof of Residence required)**

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 the 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:						
PASSPORT	MRI	EYE TEST	BLOODTESTS: HEPATITIS B & C	HIV	MBA MEDICAL EXAMINATION FORM	PROOF OF RESIDENCE

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. If the medicals result in being false, the License fee will NOT be refunded.

FOR MBA OFFICIAL USE ONLY:							
Documents Received:	PASSPORT	MRI	EYE TEST	BLOODTESTS	HIV	MEDICAL EXAMINATION FORM	PROOF OF RESIDENCE
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 _____

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 _____

Ears

Drum _____ Hearing _____ Any otitis _____

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.

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.

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: _____

Date of examination: _____

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.

TO BE SIGNED BY THE APPLICANT BOXER:

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 _____

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 _____