



## Malta Boxing Association

MBA Office - 52/1, Tigne Seafront,  
Sliema, Malta. SLM3011  
Email: maltaboxingsec@gmail.com

President: Michael Bonello

### APPLICATION FOR BOXING LICENSE(S)

#### SCHEDULE OF ANNUAL FEES & MEDICAL REQUIREMENTS.

Date: \_\_\_\_\_ MBA Number \_\_\_\_\_

Name of Applicant \_\_\_\_\_

Address \_\_\_\_\_

I.D Card No: \_\_\_\_\_ email: \_\_\_\_\_

Telephone: \_\_\_\_\_ Mobile: \_\_\_\_\_

Place of Birth: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Weight \_\_\_\_\_ Kg

Application for Pro Licence €125  Application for Novice Pro Licence €95.

Application for Amateur boxer 11-17 years old: €35  - 18+: €65

**Insurance in the sport of boxing is strongly recommended and this should be taken care of by the applicant himself.**

Club Name: \_\_\_\_\_

Name of Coach or Manager: \_\_\_\_\_

Do you have an exclusive right as a manager of Boxers listed in this application? Yes  No

*(All licences are valid for the period between 1<sup>st</sup> January and 31<sup>st</sup> December)*

#### **Medical requirements:**

**PROFESSIONAL** (Yearly): MRI/MRA; BLOODTESTS: HEPATITIS B & C; HIV + MBA Medical Examination Form filled by MBA official medical officer. (All these are valid for 12 months from date taken)

**NOVICE & AMATEUR** (Yearly): MBA Medical Examination Form filled by a qualified medical doctor (Signature & Stamp required). (All these are valid for 12 months from date taken)

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](http://nadomalta.org/wp-content/uploads/2016/05/WADA_Prohibited_List_2017_EN.pdf)

(If under 18). I confirm that I am the parent/legal guardian of the above mentioned boxer, and I hereby give consent for the above mentioned boxer to participate in competitive boxing events.

Parent/Guardian Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Boxer Signature: \_\_\_\_\_ MBA Official Signature: \_\_\_\_\_



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### BOXERS MEDICAL EXAMINATION FORM

(To be completed by a qualified medical doctor at time of application and annually when licence 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 \_\_\_\_\_ **(MUST BE REGISTERED WITH THE MBA)**

Have you held a licence 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 \_\_\_\_\_

**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.**

**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.**

Signature and stamp of examining doctor \_\_\_\_\_

COMMENTS (Any):

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**TO BE COMPLETED BY THE 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 \_\_\_\_\_

**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 movements \_\_\_\_\_

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.**

Signature and stamp of Optician/Consultant \_\_\_\_\_