



Malta Boxing Association

c/o 5, Camelia Street, Hamrun. HMR1700
Malta

Email: maltaboxingsec@gmail.com
www.maltaboxingassociation.org

APPLICATION FOR A PROFESSIONAL BOXING LICENSE

SCHEDULE OF ANNUAL FEES & MEDICAL REQUIREMENTS.

Date: _____ MBA Number _____
First Name _____ Surname: _____
Address _____

I.D Card No: _____ Email: _____
Telephone: _____ Mobile: _____
Place of Birth: _____ Date of Birth: ____/____/____ Weight _____ Kg

Application for Pro Licence €125 - To be paid upon presentation of this application.

The License Fee must be paid either by cash, BOV Mobile or 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

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 (Must be licensed by the MBA): _____

Do you have an exclusive contract with your coach/manager listed in this application? Yes No

(All licences are valid for a 12 month period starting from the date the form and payment have been submitted, and subject that the medicals being still valid)

Medical requirements: (A copy of the I.D Card or Passport must also be submitted with this form).

PROFESSIONAL (Yearly): MRI/MRA (Please note that an MRA is required if competing abroad; **EYE TESTS; 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)**

Last MRI/MRA Scan date: ____/____/____ Last Blood Tests Date: ____/____/____

Last Eye Tests Date: ____/____/____ (Copies of certificates to be attached).

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

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 is 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

(Please fill in with CAPITAL LETTERS)

First Name _____ Surname: _____

Professional Boxing Name (If different from above) _____

Address _____

Date of Birth ____ / ____ / ____ Place of Birth: _____ Marital Status _____

Tel / Mobile No. _____ Email: _____

Occupation (Other than Boxer) _____

Have you held a Boxing licence previously YES/NO (If yes, 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 _____ Kg. Describe build, etc. If overweight, is excess evenly distributed _____

If he/she has had an MRI/MRA Brain Scan, indicate date and **attach a copy** . _____ 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 _____

Ears

Drum _____ Hearing _____ Any otitis _____

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.

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.

COMMENTS (Any):

Date of Examination: _____

Signature **AND STAMP** of examining Doctor _____

Declaration by the Boxer (Applicant):

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 movements _____

Ophthalmoscopic examination (with special attention to retinal defects) _____

Date of examination _____

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Signature **AND STAMP** of Optician/Consultant _____

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 of 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.

FOR OFFICE USE ONLY

TO BE COMPLETED BY THE MALTA BOXING ASSOCIATION'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 _____