

State Athletic Control Board

P.O. Box 180 • Trenton, NJ 08625-0180 • (609) 292-0317

TO: PROFESSIONAL COMBATIVE SPORTS CONTESTANTS

RE: NEW JERSEY PROFESSIONAL BOXER/KICKBOXER/MIXED MARTIAL ARTS LICENSE APPLICATION

Enclosed are the annual requirements for application as licensed professional boxer/mixed martial arts/kickboxer contestant in the State of New Jersey.

To be licensed as a **Boxer/Mixed Martial Arts/Kickboxer** contestant, you must submit the following to this office.

1. Completed Application Form
2. Completed Physical Examination - State Form (dated within 6 months of licensure)
3. Complete HIV exam (test must be dated within 6 months of licensure/event)
4. Complete HEP B Surface AG testing & HEP C AB (test must be dated within 6 months of licensure/event)
5. Complete Blood Count (CBC) and Bleeding & Coagulation (PT/PTT Pro-Time)-(dated within 6 months of licensure)
6. Original EKG report, read by a physician (dated within 6 months of licensure)
7. Original CT/MRI Brain SCAN report (without contrast), read by a physician (dated within 3 years of licensure/event)
8. Original EYE examination by an ophthalmologist - ophthalmological dilation (dated within 6 months of licensure)
9. Serum Pregnancy test (dated within 30 days of licensure/event & repeated within 30 days of each event)
10. Check or money order in the amount of \$5.00, payable to the State Athletic Control Board

**NOTE:** Proof of medical testing must be provided through **"ORIGINAL DOCUMENTS"** indicating date of test, location of test and identification of the doctor. The date, location and name of doctor who reviews the medical test results must also be provided.

**IMPORTANT:** The New Jersey Boxer License that you receive will be effective for **Twelve (12)** months from date of issue.

To reduce the costs for individuals tests, the Board has obtained an agreement from Inspira Health Network formerly known as Occupational Health, Bridgeton Health Center to provide medical testing at specific rates. For further information contact:

Joan Pierce  
Inspira Health Network  
Combatant Sports Medicine  
Imaging Center  
201 Tomlin Station Rd.  
Mullica Hill, NJ 08062  
Phone: 888-585-9875 or  
856-241-2563  
Fax: 856-453-1218  
E-Mail: [piercej@ihn.org](mailto:piercej@ihn.org)

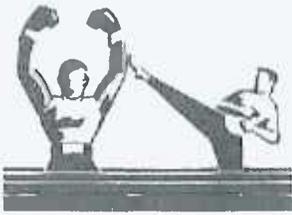
Applicants are reminded: You are subjected to the requirements of the State Athletic Control Board rules, provided by Chapter 46 of the New Jersey's Administrative Code.

Take note of "Subchapter 5 Boxers" under the rules, and the subject of Boxer-Manager contracts within New Jersey. Submitting a valid Boxer-Manager contract to this office may avoid possible disputes or court action.

Important: Effective immediately all boxer-manager contracts shall be executed and signed in the presence of the commissioner. In order to have the contract recognized, please schedule an appointment with the commissioner.

If there are any questions regarding your application, please contact this office at 609.292.0317.

LH/tg  
Enclosure  
05.2016



State Athletic Control Board

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Dear Applicant:

Please be advised that new procedures for obtaining a SACB license are being implemented. Please note and adhere to the directions below.

**Procedures for Applicants Scheduled to Work an Event**  
**(this includes initial and/or renewal status)**

CONTACT EVENT PROMOTER AND/OR MATCHMAKER BEFORE COMPLETING THE BELOW STEPS

All application packets must be completed in full and received by the **Promoter** and/or **Matchmaker** no later than three(3) days prior to the event. Application packets will consist of:

- An application
- A digital photo ID (driver's license or passport) e-mailed via jpeg or bitmap format (cannot be faxed) – if applicable
- A digital "head shot" photo e-mailed jpeg or bitmap format (cannot be faxed) – if applicable
- License fee/s will be deducted from the fighter's purse

NEW JERSEY STATE ATHLETIC CONTROL BOARD

**\*\*PLEASE MAKE CHECK OR MONEY ORDER PAYABLE TO N.J.S.AC.B \*\*\*NO CASH!!\*\*\***  
**NEW JERSEY STATE ATHLETIC CONTROL BOARD - LICENSE APPLICATION**

P.O. Box 180, Trenton, NJ 08625-0180

Telephone: 609.292.0317 Office Fax: 609.341.5038

**SECTION I - All Applicants Complete Check (✓) or circle Type/s of License**

<b>Last Name:</b>	<b>CONTESTANT</b>	<b>MANAGER</b>	<b>SECOND</b>	<b>ANNOUNCER</b> <input type="checkbox"/> \$100
	Boxer <input type="checkbox"/> \$5	Boxing <input type="checkbox"/> \$25	Boxing <input type="checkbox"/> \$25	<b>TIMEKEEPER</b> <input type="checkbox"/> \$100
	Kickboxer <input type="checkbox"/> \$5	Kickboxer <input type="checkbox"/> \$25	Kickboxer <input type="checkbox"/> \$25	<b>INSPECTOR</b> <input type="checkbox"/> \$0
<b>First Name:</b>	MMA <input type="checkbox"/> \$5	MMA <input type="checkbox"/> \$25	MMA <input type="checkbox"/> \$25	<b>PHYSICIAN</b> <input type="checkbox"/> \$0
	<b>REFEREE</b>	<b>JUDGE</b>	<b>PROMOTER</b>	<b>MATCHMAKER</b>
	Boxing <input type="checkbox"/> \$100	Boxing <input type="checkbox"/> \$100	Boxing <input type="checkbox"/> \$300	Boxing <input type="checkbox"/> \$100
<b>Middle Name:</b>	Kickboxing <input type="checkbox"/> \$100	Kickboxing <input type="checkbox"/> \$100	Kickboxing <input type="checkbox"/> \$300	Kickboxing <input type="checkbox"/> \$100
	MMA <input type="checkbox"/> \$100	MMA <input type="checkbox"/> \$100	MMA <input type="checkbox"/> \$300	MMA <input type="checkbox"/> \$100
	Amateur MMA <input type="checkbox"/> \$100	Amateur MMA <input type="checkbox"/> \$100	Amateur MMA <input type="checkbox"/> \$300	Amateur MMA <input type="checkbox"/> \$100
<b>AKA or Alias:</b>				

Address:	City:	State:	Zip:	Country:
Mailing Address:	City:	State:	Zip:	Country:

Date of Birth: ____/____/____	Sex: <b>Male</b> <b>Female</b>	Have you ever been convicted of a crime? If yes, explain: <b>YES</b> <b>NO</b>
Social Security No. ____/____/____	<b>Height</b> <b>Weight</b> ____	Are you presently on any suspension list? If yes, please explain: <b>YES</b> <b>NO</b>
Citizenship:	Place of Birth (City/State):	Have you ever been disqualified in any contest or disciplined for your actions during a contest? If yes, please explain: <b>YES</b> <b>NO</b>
E-Mail:		Has any license you've held been revoked? <b>YES</b> <b>NO</b> If yes, please explain:
Telephone:(Residence) ( )	Telephone:(Business) ( )	List all other Athletic Commissions in which you are licensed:
Telephone: (Cell) ( )	Fax: ( )	NJSACB Office Use

**Section II - Boxer's, Kickboxer's & Mixed Martial Artist Only - Please Print**

Have you ever been hospitalized due to an injury suffered in any contest? If YES, please explain <b>YES</b> <b>NO</b>	Do you have any current medical conditions? <b>YES</b> <b>NO</b> If YES, please explain.
Have you had amateur experience? <b>YES</b> <b>NO</b> Amateur Record: _____ Number of Fights: _____	
Submission Grappling Record: _____ Name of Gym or Club where you trained: _____	
Do you have a <b>Manager</b> and/or <b>Trainer</b> ? <b>YES</b> <b>NO</b> If yes, provide name	
Manager Name: _____	Address: _____ Contact # _____
Trainer Name: _____	Address: _____ Contact# _____

**SECTION II (continued) \*\*Fighters Only\*\* Communicable Bodily Fluid Virus High-Risk Questionnaire\*\***

1. Do you have any immediate family members who have HIV, Hepatitis B or C? **YES NO** If yes, please provide detail.  
\_\_\_\_\_
2. Have you received a transfusion of blood or blood components? **YES NO** If yes, specify date, location, reason  
\_\_\_\_\_
3. Have you had surgery requiring blood products? **YES NO** If yes, specify date, location, reason  
\_\_\_\_\_
4. Have you used injectable drugs? **YES NO** If yes, specify date of most recent injection \_\_\_\_\_
5. Have you been sexually active with an individual who has HIV, Hepatitis B or C? **YES NO** If Yes, please provide most recent date of such activity: \_\_\_\_\_
6. Have you engaged in unprotected sex? **YES NO** If Yes, please provide most recent date of such activity \_\_\_\_\_
7. Have you had sex with a injectable user? **YES NO** If Yes, please provide most recent date of such activity \_\_\_\_\_
8. Have you worked in a health care or laboratory setting? **YES NO** If Yes, please provide appropriate dates: \_\_\_\_\_
9. Have you been imprisoned or worked in a prison or any type of correctional facility: **YES NO** If Yes provide appropriate dates: \_\_\_\_\_
10. Do you have any tattoos or body piercing? **YES NO** If Yes, when was most recent one obtained \_\_\_\_\_
11. Do you have any reason to believe that you may have contracted HIV or Hepatitis B or C at anytime? **YES NO**  
If Yes, explain: \_\_\_\_\_

**SECTION III (Manger's and Second's Only) Please Print**

List names of fighter/s which you currently manage or second:  
\_\_\_\_\_

Do you know of any medical conditions the above fighter(s) currently have? **Yes No** If YES, please explain:  
\_\_\_\_\_

**SECTION IV - ALL APPLICANTS MUST COMPLETE THIS SECTION - Child Support Certification Process**

Please certify, under penalty of perjury, the following::

Yes	No	1) Do you currently have a child support obligation?
Yes	No	1a) If YES, are you in arrears in payment of said obligation?
Yes	No	1b) If "YES", does the arrearage match or exceed the total amount payable for the past six months
Yes	No	2) Have you failed to provide any court ordered health insurance coverage during the past six months
Yes	No	3) Have you failed to respond to a subpoena relating to either paternity or child-support proceeding?
Yes	No	4) Are you the subject of a child-support related arrest warrant?

In accordance with N.J.S.A.2A:17-56.44d, an answer "Yes" to any of the numbered questions 1a through 4 will result in a denial of licensure. Furthermore, any false certification of the above may subject you to a penalty, including, but not limited to, immediate revocation or suspension of licensure.

I THE UNDERSIGNED HEREBY DECLARE THAT I HAVE READ THIS APPLICATION AND THAT ALL THE ANSWERS TO THE QUESTIONS ARE TRUE, AND COMPLETE. I UNDERSTAND THAT ANY MISREPRESENTATION OR FAILURE TO ANSWER SHALL CONSTITUTE GROUNDS FOR LICENSE REVOCATION AND OR OTHER APPLICABLE LEGAL PENALTIES.

I ALSO UNDERSTAND THAT BY SIGNING THIS APPLICATION THAT I AM AUTHORIZING THE STATE ATHLETIC CONTROL BOARD TO CONDUCT A FULL INVESTIGATION INTO MY BACKGROUND AND ACTIVITIES. I UNDERSTAND THAT THE OFFICE OF THE ATTORNEY GENERAL AND THE NEW JERSEY STATE POLICE MAY PARTICIPATE IN THIS BACKGROUND INVESTIGATION.

TO ALL COURTS, PROBATION DEPARTMENTS, SELECTIVE BOARDS, EMPLOYERS, EDUCATION INSTITUTIONS FINANCIAL INSTITUTIONS AND ALL GOVERNMENT AGENCIES, FEDERAL, STATE AND LOCAL, WITHOUT EXCEPTION, BOTH FOREIGN AND DOMESTIC. I HAVE APPLIED FOR A LICENSE WITH STATE ATHLETIC CONTROL BOARD AND FOR THE PURPOSE OF THIS APPLICATION, YOU ARE HEREBY AUTHORIZED TO RELEASE ANY AND ALL INFORMATION PERTAINING TO ME, DOCUMENTARY OR OTHERWISE, AS REQUESTED BY ANY APPROPRIATE EMPLOYEE, AGENT OR REPRESENTATIVE OF THE STATE ATHLETIC CONTROL BOARD, THE OFFICE OF THE ATTORNEY GENERAL OR THE NEW JERSEY STATE POLICE.

I THE UNDERSIGNED STATE THAT A PHOTOSTATIC OF THIS AUTHORIZATION WILL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

FURTHER, I AM AWARE AND AGREE THAT MY SIGNATURE CONSTITUTES A WAIVER OF LIABILITY AS TO THE STATE OF NEW JERSEY AND ITS INSTRUMENTALITIES AND AGENTS FOR ANY DAMAGE RESULTING IN DISCLOSURE OR PUBLICATION IN ANY MANNER, OTHER THAN A WILLFULLY UNLAWFUL DISCLOSURE OR PUBLICATION, OF ANY MATERIAL OR INFORMATION ACQUIRED DURING THE LICENSURE CONSIDERATION PROCESS OR DURING ANY INVESTIGATIONS, INQUIRY OR HEARING.

I HEREBY AUTHORIZE THAT RELEASE OF ANY CRIMINAL HISTORY RECORD INFORMATION TO THIS AGENCY ONLY FOR THE EXPRESS PURPOSE OF PROCESSING MY APPLICATION FOR A LICENSE. THE AUTHORITY TO REQUEST CRIMINAL INFORMATION IS SET FORTH IN THE N.J.S.A.5:2a-15.

I UNDERSTAND THAT THE DISCLOSURE OF MY SOCIAL SECURITY NUMBER ON THIS APPLICATION IS VOLUNTARY AND THAT IT WILL ONLY BE USED FOR PURPOSES OF PROCESSING MY APPLICATION.

PRINT NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

**NEW JERSEY STATE ATHLETIC CONTROL BOARD**  
**P.O. BOX 180 TRENTON NJ 08625**  
**PHONE 609-292-0317 FAX 609-341.5038**  
**PROFESSIONAL COMBATIVE SPORTS CONTESTANT PHYSICAL EXAMINATION**

Contestant Name: \_\_\_\_\_  
 Street Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I certify that I have examined the above named contestant on \_\_\_\_\_ and have found him/her to be medically cleared to engage in an professional combative sport competition.

Physician Name (printed): \_\_\_\_\_  
 Physician Signature: \_\_\_\_\_

Physician Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Office Phone: \_\_\_\_\_ Physician's License Number: \_\_\_\_\_

**CONTESTANT EXAMINATION:**

Height: \_\_\_\_\_  
 Weight: \_\_\_\_\_  
 Sex: \_\_\_\_\_  
 Blood Pressure: \_\_\_\_\_  
 Pulse: \_\_\_\_\_  
 Temperature: \_\_\_\_\_  
 Blood Type: \_\_\_\_\_  
 Allergies:  
 \_\_\_\_\_  
 Medications:  
 \_\_\_\_\_  
 Any enlarged glands:  
 \_\_\_\_\_  
 Ears - Otoscopy:  
 \_\_\_\_\_  
 Mouth Pharynx:  
 \_\_\_\_\_  
 Lungs:  
 \_\_\_\_\_  
 Heart:  
 Must include check for Murmurs:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Abdomen:  
 Abdominal Palpation:  
 Hernias:  
 Enlargement of Liver:  
 Enlargement of Spleen:

Testis:  
 \_\_\_\_\_  
**NEUROLOGICAL:**  
 Knee Jerk:  
 \_\_\_\_\_  
 Babinski:  
 \_\_\_\_\_  
 Rhomberg:  
 \_\_\_\_\_  
 Finger to nose:  
 \_\_\_\_\_  
 Gait:  
 \_\_\_\_\_  
 Brudzinski:  
 \_\_\_\_\_  
 Cranial Nerves:  
 \_\_\_\_\_  
 Bicep Jerks:  
 \_\_\_\_\_  
**UPPER EXTREMITIES:**  
 Hands:  
 \_\_\_\_\_  
 Wrist:  
 \_\_\_\_\_  
 Elbows:  
 \_\_\_\_\_  
 Shoulder:  
 \_\_\_\_\_  
 Lower Extremities:  
 \_\_\_\_\_

Skin:  
 Open or Superlative lesions:  
 Rashes:  
 Any unhealed cuts:  
 \_\_\_\_\_  
 Any indications of active renal disease:  
 \_\_\_\_\_  
**PHYSICAL HISTORY:**  
 Chest Pains:  
 \_\_\_\_\_  
 Fainting Spells:  
 \_\_\_\_\_  
 Chest Palpitations:  
 \_\_\_\_\_  
 Hemoptysis or Vomiting of Blood  
 \_\_\_\_\_  
 Shortness of Breath  
 \_\_\_\_\_  
 Frequent Headaches:  
 \_\_\_\_\_  
 Convulsions:  
 \_\_\_\_\_  
 Past Head Injury or Concussions:  
 \_\_\_\_\_  
 Operations:  
 \_\_\_\_\_  
 Diabetes:  
 \_\_\_\_\_  
 Unconsciousness from training or competing:  
 \_\_\_\_\_

**FOR WOMEN:**

Pregnancy Test:

\_\_\_\_\_

Breast Exam:

\_\_\_\_\_

Gynecological Exam:

\_\_\_\_\_

**PHYSICIAN COMMENTS:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PHYSICAL HISTORY(CONTNUED):**

Unconsciousness from any other sport or for any other reason:

\_\_\_\_\_

\_\_\_\_\_

Sickle Cell Disease:

\_\_\_\_\_

Infectious Disease:

\_\_\_\_\_

**DILATED EYE EXAMINATION MUST BE PERFORMED BY AN OPHTHALMOLOGIST**

EYES

RIGHT

LEFT

Distant Vision:

Light Reflex:

Accommodation Reflex:

Fundi:

Cataracts:

Wears Contact Lenses: \_\_\_\_\_

Has patient had blurred vision?

If yes, please detail: \_\_\_\_\_

Has patient had surgical procedures done to his/her eyes or the tissues around the eye?

If yes, please detail: \_\_\_\_\_

Has applicant ever had a retinal tear, retinal detachment, glaucoma, aphakia, or dislocated lens?

If yes, please detail: \_\_\_\_\_

Does patient have different size pupils?

If yes, please explain: \_\_\_\_\_

**I certify that I have examined the above contestant on \_\_\_\_\_ and have found nothing in his//her eye examination which would prohibit engaging in an professional combative sport competition.**

Ophthalmologist Name (printed) \_\_\_\_\_

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

Ophthalmologist Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

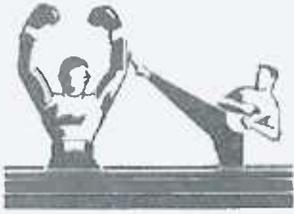
Office Phone: \_\_\_\_\_ Physician's License Number: \_\_\_\_\_

**I hereby declare that the foregoing information is true, complete and correct. I understand that any misrepresentation may subject me to license revocation and applicable legal penalties.**

Contestant's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Contestant (PRINT NAME) \_\_\_\_\_



State Athletic Control Board

P.O. Box 180 • Trenton, NJ 08625-0180 • (609) 292-0317

TO: All Boxers/Mixed Martial Artists/Kickboxers  
SUBJECT: Pre-Fight Medicals Questionnaire  
DATE: May 2016

Please be advised that all medical questions appearing on SACB pre-fight questionnaires are designed to ascertain information relative to any existing medical condition you may be presently experiencing. If you are currently taking prescribed medication and/or have recently been treated for any injury, you should answer "yes" to the question. Answering "yes" does not automatically mean that you will be disqualified from participating. However, if you fail to honestly disclose the information to us prior to your participation, and it is revealed during the post-fight physical examination or through the drug testing process you will be suspended.

LH/tg

c: Nicholas Lembo  
Ringside Physicians