



# State of New Jersey

OFFICE OF THE ATTORNEY GENERAL  
DEPARTMENT OF LAW AND PUBLIC SAFETY  
STATE ATHLETIC CONTROL BOARD  
P.O. Box 180  
TRENTON, NJ 08625-0180

CHRIS CHRISTIE

*Governor*

KIM GUADAGNO

*Lt. Governor*

PAULA T. DOW

*Attorney General*

TONY ORLANDO

*Chairman*

STEVEN KATZ  
DENNIS McDONOUGH  
*Members*

AARON M. DAVIS  
*Commissioner*

TO: PROFESSIONAL COMBATIVE SPORTS CONTESTANTS

FMA Aaron M. Davis  
Commissioner

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 - Boxer Form (dated within 6 months of licensure/event)
3. Complete HIV exam (not required to obtain a license, however, to compete in an event, test must be dated within 6 months of event)
4. Complete HEP B Surface AG testing & HEP C AB (not required to obtain a license, however, to complete in an event, test must be dated within 6 months of event)
5. Complete Blood Count (CBC) and Bleeding & Coagulation (PT/PTT Pro-Time)
6. Original EKG report, read by a physician (dated within 6 months of licensure/event)
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/event)
9. Serum Pregnancy test (dated within 30 days of licensure/event & repeated within 30 days of each event)
10. Annual Physical/Clinical Gynecological & Breast Exam for women (dated within 30 days of licensure/event)
11. 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 Occupational Health, Bridgeton Health Center to provide medical testing at specific rates. For further information contact:

Occupational Health  
Bridgeton Health Center,  
Ground Floor  
333 Irving Avenue  
Bridgeton, New Jersey 08302.  
Phone: 856.575.4835 (direct phone #)  
Fax: 856.453.1218  
E-Mail: [piercej@sjhs.com](mailto:piercej@sjhs.com)

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 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.

A.M.D.

AMD/tg  
Enclosure  
01.2010



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**AARON M. DAVIS**  
*Commissioner*

January 2010

Dear Applicant:

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

All application packets must be completed in full and received by New Jersey State Athletic Control Board office no later than 4:00 p.m. two 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)
- a signature in bold pen spanning the width of an 8.5 x 11 sheet of paper
- a digital "head shot" photo (cannot be faxed) and if e-mailed jpeg or bitmap format
- a check or money order covering all fees (made payable to N.J.S.A.C.B.)

Application packets can be submitted by e-mail ([SACBLicensing@lps.state.nj.us](mailto:SACBLicensing@lps.state.nj.us)), US mail, or in person at the Trenton office.

No license will be issued until all requirements are met.

Sincerely,

Aaron M. Davis  
Commissioner  
SACB

AMD/tg

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**\*\*PLEASE MAKE CHECK OR MONEY ORDER PAYABLE TO N.J.S.A.C.B. \*\***

**\*\*\*\*NO CASH!!\*\*\*\***

**NEW JERSEY STATE ATHLETIC CONTROL BOARD  
LICENSE APPLICATION**

P. O. Box 180

Trenton, New Jersey 08625-0180

Telephone: (609)292-0317 Office Fax: (609)341-5038 Medicals Fax: (609)292-3756

SACB Webstie: [www.nj.gov/oag/sacb](http://www.nj.gov/oag/sacb)

**Check (✓) or Circle Type/s of License**

<u>CONTESTANT</u>	<u>MANAGER</u>	<u>SECOND</u>	
<input type="checkbox"/> Boxer \$5	<input type="checkbox"/> Boxing \$25	<input type="checkbox"/> Boxing \$25	<input type="checkbox"/> Announcer \$25
<input type="checkbox"/> Kickboxer \$5	<input type="checkbox"/> Kickboxing \$25	<input type="checkbox"/> Kickboxing \$25	<input type="checkbox"/> Timekeeper \$25
<input type="checkbox"/> Mixed Martial Artist \$5	<input type="checkbox"/> Mixed Martial Arts \$25	<input type="checkbox"/> Mixed Martial Arts \$25	<input type="checkbox"/> Other \$ _____

<u>REFEREE</u>	<u>JUDGE</u>	<u>PROMOTER</u>	<u>MATCHMAKER</u>
<input type="checkbox"/> Boxing \$75	<input type="checkbox"/> Boxing \$75	<input type="checkbox"/> Boxing \$300	<input type="checkbox"/> Boxing \$100
<input type="checkbox"/> Kickboxing \$75	<input type="checkbox"/> Kickboxing \$75	<input type="checkbox"/> Kickboxing \$300	<input type="checkbox"/> Kickboxing \$100
<input type="checkbox"/> Mixed Martial Arts \$75	<input type="checkbox"/> Mixed Martial Arts \$75	<input type="checkbox"/> Professional Mixed Martial Arts \$300	<input type="checkbox"/> Mixed Martial Arts \$100
<input type="checkbox"/> Amateur MMA	<input type="checkbox"/> Amateur MMA	<input type="checkbox"/> Amateur Mixed Martial Arts \$300	<input type="checkbox"/> Amateur Martial Arts \$100

**SECTION I (All Applicants) - Please Print**

NAME: \_\_\_\_\_ AKA or ALIAS (Other Names Used): \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ COUNTRY: \_\_\_\_\_

MAILING ADDRESS (complete if different from above) CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ COUNTRY: \_\_\_\_\_

TELEPHONE (Residence): ( ) \_\_\_\_\_ TELEPHONE (Business): ( ) \_\_\_\_\_ FAX#: ( ) \_\_\_\_\_ E-MAIL ADDRESS: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY#: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

SEX:  MALE  FEMALE CITIZENSHIP: \_\_\_\_\_ PLACE OF BIRTH: \_\_\_\_\_

Have you ever been convicted of a crime? If yes, explain:  YES  NO

Are you presently on any suspension list? If yes, explain:  YES  NO

Have you ever been disqualified in any contest or disciplined for your actions during a contest?  YES  NO  
If yes, explain: \_\_\_\_\_

Has any license you've held been revoked? If yes, please explain:  YES  NO

List all other Athletic Commissions in which you are licensed:

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**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, explain:  YES  NO

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Do you have any current medical conditions? If yes, please explain:  YES  NO

---

Do you have a manager? If yes, provide name, address & telephone number:  YES  NO

Name: \_\_\_\_\_ Address: \_\_\_\_\_ Telephone No: (\_\_\_\_) \_\_\_\_\_

---

Have you had amateur experience? If yes, complete the following questions:  YES  NO

Amateur Record: \_\_\_\_\_ Number of Fights: \_\_\_\_\_

Submission Grappling Record: \_\_\_\_\_

Name of Gym or Club where you trained: \_\_\_\_\_

Name and Telephone Number of Trainer or Manager:

Name: \_\_\_\_\_ Telephone Number: (\_\_\_\_) \_\_\_\_\_

---

**SECTION III (Manager's & Second's Only) Please Print**

List names of boxers which you currently manage/second:

---

Do you know of any medical conditions which your boxers currently have?: If yes, please explain  YES  NO

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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, EDUCATIONAL INSTITUTIONS, FINANCIAL INSTITUTIONS AND ALL GOVERNMENT AGENCIES, FEDERAL, STATE AND LOCAL, WITHOUT EXCEPTION, BOTH FOREIGN AND DOMESTIC. I HAVE APPLIED FOR A LICENSE WITH THE 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 COPY 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 DAMAGES 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 THE 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 FOR IN N.J.S.A. 5:24-15.

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.

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

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



**State of New Jersey  
Department of Law & Public Safety  
State Athletic Control Board**

**CHILD SUPPORT QUESTIONS**

Please certify, under penalty of perjury, the following:

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

In accordance with N.J.S.A. 2A:17-56.44d, an answer of "YES" to any of the questions numbered 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.

\_\_\_\_\_

Applicant's Name (please print)	Applicant's Signature	Date
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**\*Social Security Number:**      \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

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## COMMUNICABLE BODILY FLUID VIRUS HIGH-RISK QUESTIONNAIRE

### **\*\*FIGHTERS ONLY\*\***

1. Do you have any immediate family members who have HIV, Hepatitis B or C?  
If yes, please provide detail.  Yes  No

---

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
6. Have you engaged in unprotected sex?  Yes  No
7. Have you had sex with an injectable drug user?  Yes  No  
If yes to questions 5 through 7, 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, please 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 any time?  
 Yes  No If yes, explain: \_\_\_\_\_

Contestant's Name: \_\_\_\_\_ Contestant's Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_



**NEW JERSEY STATE ATHLETIC CONTROL BOARD  
P.O. BOX 180 TRENTON NJ 08625  
PHONE 609-292-0317 FAX 609-292-3756  
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: \_\_\_\_\_



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*Commissioner*

TO: All Boxers/Mixed Martial Artists/Kickboxers  
FROM:  Aaron M. Davis, Commissioner, SACB  
SUBJECT: Pre-Fight Medicals Questionnaire  
DATE: October 2009

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.

AMD/tg

c: Nicholas Lembo  
Ringside Physicians

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