



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 BOXING/MIXED MARTIAL ARTS/KICKBOXING & Amateur
MIXED MARTIAL ARTS JUDGES/REFEREES

FROM:  Aaron M. Davis
Commissioner

SUBJECT: New Jersey Professional Boxing/Mixed Martial Arts/Kickboxing & Amateur Mixed
Martial Arts Judge/Referee License Application
RENEWAL: July 1, 2010 - June 30, 2011

**Enclosed are the annual requirements for license as a Professional Boxer/Mixed
Martial Arts/Kickboxer & Amateur Mixed Martial Artist Judge/Referee in the State of New
Jersey.**

You must submit the following to this office:

1. Completed License Application Forms
2. Completed Physical Examination Form
3. Completed Official's Disclosure Form
4. Original EKG report, interpreted by a physician
5. Original EYE examination by optometrist
6. Check or money order in the amount of \$75.00 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. Medical tests and examinations must be dated within **180** days of application.

To reduce the costs for individual 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

AN INCOMPLETE APPLICATION WILL BE RETURNED TO YOU, DELAYING ISSUE OF YOUR LICENSE AND FUTURE SHOW ASSIGNMENTS.

LICENSEES ARE REMINDED: You are subject to the requirements of State Athletic Control Board Rules, provided by Chapter 46 of New Jersey's Administrative Code.

If there are any questions regarding your application, please contact the office.

AM/Dtg
Enclosures
REV: 01.2010



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January 2010

Dear Applicant:

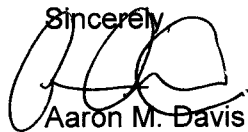
Please be advised that new procedures for obtaining a SACB license are being implemented. Please note and adhere to the directions below.

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), 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

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:

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

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

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:

- | | Yes | No |
|---------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 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

***Social Security Number:** _____ - _____ - _____

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OFFICIAL'S DISCLOSURE FORM

1. What is your profession or occupation? _____

2. Who is your current employer? _____

If not currently employed, please list your most recent employer?

3. What is your business address and telephone number?

4. What is your home address and telephone number?

-over-

5. Are you licensed as a professional boxing official in any other jurisdiction?

YES

NO

(If yes, please explain) _____

6. Has any boxing license you have ever held been suspended or revoked?

YES

NO

(If yes, please explain) _____

7. Have you ever been denied a professional boxing official's license?

YES

NO

(If yes, please explain) _____

8. Do you have any direct or indirect financial interest in, or direct or indirect financial dealings with, any professional boxer, manager, second, trainer, promoter, matchmaker, sanctioning organization, or boxing media personality?

YES

NO

(If yes, please explain) _____

-more-

9. Do you have any direct or indirect financial interest with any company, partnership, or individual who is involved in the sport of boxing?

YES

NO

(If yes, please explain) _____

10. Please list all organizations, associations, groups, or charitable foundations related to boxing that you are currently a member of, or have been in, the last 12 months.

11. Are you, your spouse, or any of your parents, brothers, sisters, cousins, nieces, nephews, aunts, uncles, or grandchildren related to any professional boxer, manager, second, trainer, promoter, matchmaker, sanctioning organization official, or boxing media personality?

YES

NO

(If yes, please explain) _____

12. Are you, your spouse, or any of your parents, brothers, sisters, cousins, nieces, nephews, aunts, uncles, or grandchildren a personal friend of any professional boxer, manager, second, trainer, promoter, matchmaker, sanctioning organization official, or boxing media personality?

YES

NO

(If yes, please explain) _____

-over-

13. Have you been offered or received any gifts, complementaries, or other things of value from any professional boxer, manager, second, trainer, promoter, matchmaker, sanctioning organization, or boxing media personality?

YES

NO

(If yes, please explain) _____

14. Have you been arrested by any law enforcement agency in the past twelve months?

YES

NO

(If yes, please explain) _____

I CERTIFY THAT THE INFORMATION WHICH I HAVE PROVIDED ABOVE IS TRUE AND ACCURATE AND I UNDERSTAND THAT IT IS MY OBLIGATION TO NOTIFY THE SACB, IN WRITING, IMMEDIATELY, IF ANY OF MY RESPONSES TO THE ABOVE QUESTIONS CHANGE. I FURTHER UNDERSTAND THAT ANY OMISSIONS, INACCURACIES OR THE FAILURE TO MAKE FULL DISCLOSURES MAY BE DEEMED SUFFICIENT REASON TO DENY A LICENSE OR TO WITHHOLD RENEWAL OF, OR SUSPEND OR REVOKE, A LICENSE IF ISSUED BY THE BOARD. THE UNDERSIGNED APPLICANT UNDERSTANDS THE BOARD OR COMMISSIONER MAY MAKE SUCH INQUIRY AND INVESTIGATION CONCERNING THE APPLICANT'S RECORD OR BACKGROUND AS THE BOARD OR COMMISSIONER, IN THEIR JUDGEMENT, DEEMS PROPER, AND SAID APPLICANT FURTHER AGREES TO FURNISH ANY ADDITIONAL INFORMATION REQUESTED BY THE BOARD OR COMMISSIONER.

Date: _____

Print Name: _____

Signature: _____

This form must be faxed back to the SACB at (609) 292-3756 at least 10 days before the scheduled event in order to be considered for a position at that event. If you have any questions, please contact the SACB at (609) 292-0317.

Please return this form to:

State of New Jersey
State Athletic Control Board
140 East Front Street
P.O. Box 180
Trenton, NJ 08625-0180

PHYSICAL EXAMINATION - OFFICIALS

- Blood Pressure no higher than 90 m/m Hg.
- Temperature below 100°F or 37°C
- Fundi - no retinopathies or cataracts
- No hernias nor visceromegaly
- Normal Rhombberg and finger to nose test
- No suppurative lesions on skin
- No indications of active renal disease

EXAMINATION

Ears

Otoscopy (Normal-Abnormal) Describe: _____

Mouth pharynx (teeth) (Normal-Abnormal) Describe: _____

Adenopathys No Yes (Location) _____

Lungs (Normal-Abnormal) Describe: _____

Heart (Normal-Abnormal) Describe: _____

Abdominal palpation (Normal-Abnormal) Describe: _____

Hernias (No-Yes) Describe: _____

Testis (Normal-Abnormal) Describe: _____

Tendon Reflexes Normal Abnormal

Knee jerk Rt. Lft. Rt. Lft.

Babinski Rt. Lft. Rt. Lft.

Rhombberg: _____

Finger to nose: _____

Upper Extremities (Normal-Abnormal) Describe: _____

Hands: _____

Wrist: _____

Elbows: _____

Shoulder Girdle: _____

Lower Extremities: _____

Skin (Open or Suppurative lesions) Yes No

Urinalysis: _____

Albumin: _____

Glucose: _____

Micro: _____

Hematuria: _____

Blood-test: _____

Hemaglobin and Hematocrit _____

Electrocardiogram _____ Date: _____

Examiners comments: _____

Physician Name (printed): _____

Address: _____

Phone: _____

Name: _____

Home Address: _____

Phone: _____

Birth Date: _____

Exam Date: _____

IMPORTANT

BLOOD TYPE: _____

ALLERGIES: _____

Pulse: _____ Blood Pressure: _____

Temperature: _____ Weight: _____

OPTOMETRIST EXAM DATE: _____

EYES RIGHT LEFT

Distant Vision 20/ 20/

Light Reflex Normal Abnormal Normal Abnormal

Accommodation Reflex Normal Abnormal Normal Abnormal

Comments: _____

Physician: Name (printed): _____

Address: _____

Phone: _____

**STATE OF NEW JERSEY
W-9 QUESTIONAIRE**

THE STATE OF NEW JERSEY REQUIRES COMPLETION OF THE W-9 VENDOR QUESTIONAIRE TO VERIFY/ESTABLISH YOUR NAME, ADDRESS, AND TAXPAYER ID ON STATE RECORDS. PLEASE REVIEW THE INFORMATION BELOW, CORRECT ERRORS, AND ANSWER THE QUESTIONS PER SPECIFIC INSTRUCTIONS. RETURN THE COMPLETED FORM TO THE STATE IN THE ENVELOPE PROVIDED AS SOON AS POSSIBLE.

IMPORTANT: YOU WILL NOT BE PAID BY THE STATE OF NEW JERSEY UNTIL THIS FORM IS COMPLETED, SIGNED, AND RETURNED TO THE STATE OF NJ. FOR ADDITIONAL INFORMATION CALL (609) 292-8124.

PART I. NAME/ADDRESS	REQUEST FOR TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION	Return completed form to:
(REMIT TO:)	Enter your taxpayer identification number and indicate whether it is a social security or employee identification number by marking the appropriate box.	Language Services Section Administrative Office of the Courts P.O. Box 988 Trenton, NJ 08625-0988

Make any corrections to the pre-printed data in the space provided below. Please type or print clearly.

4. Taxpayer Identification Number (Enter your correct TIN below ONLY if it differs from the # printed in the box.)	MARK THE APPROPRIATE BOX:	Internal Use Only
<input style="width:100%;" type="text"/>	<input type="checkbox"/> SOCIAL SECURITY NUMBER <input type="checkbox"/> EMPLOYEE IDENTIFICATION NUMBER	

5. For Employees Exempt From Backup Withholding (Contact the IRS for instructions)	Requester's name and address (optional)
-------------------------------------------------------------------------------------------	------------------------------------------------

6. Certification: Under penalties of perjury, I certify that:

(1) The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me) AND

(2) I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding.

Certification Instructions: You must cross out item (2) above if you have been notified by the IRS that you are currently subject to backup withholding because of underreported interest or dividends on your tax return. For real estate transactions, item (2) does not apply. For mortgage interest paid, the acquisition or abandonment of secured property, cancellation of debt, contributions to an IRA, and generally payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN.

Please Sign Here	Signature > _____	Date > _____
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PART II. VENDOR DATA	STATE OF NEW JERSEY VENDOR INFORMATION QUESTIONAIRE
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1. Enter the code from the list below that best describes your business function:

VENDORS	GOVERNMENTAL ENTITIES
HC = HEALTH CARE SERVICE (NON-STATE AGENCIES) VG = VENDORS WHO SELL OR MANUFACTURE GOODS VS = VENDORS WHO RENDER A SERVICE OR VENDORS WHO RECEIVE RENT PAYMENTS	AC = AUTHORITY/ COMMISSION CF = CONFIDENTIAL FUND CM = COUNTY/MUNICIPAL GOVT. CU = STATE COLLEGE/UNIVERSITY EP = NJ STATE EMPLOYEE FA = FEDERAL AGENCY FD = FIRE DISTRICT PC = PETTY CASH SA = STATE AGENCY SD = SCHOOL DISTRICT WB = WELFARE BOARD

MISCELLANEOUS VENDORS

OT = OTHER MISCELLANEOUS VENDORS (PLEASE SPECIFY) _____

2. Enter Primary Contact Information Below.

PHONE: _____ NAME: _____ TITLE: _____

IF YOU ARE A NJ STATE EMPLOYEE, NJ MANAGER OF A CONFIDENTIAL FUND OR A PETTY CASH FUND, DO NOT ANSWER THE BALANCE OF THE QUESTIONAIRE.

3. What is the principle activity of your organization?

<input type="checkbox"/> M = MANUFACTURING	<input type="checkbox"/> H = HEALTH RELATED SERVICE	O = OTHER (Please Specify) _____
<input type="checkbox"/> S = SERVICE	<input type="checkbox"/> G = GOVERNMENT	

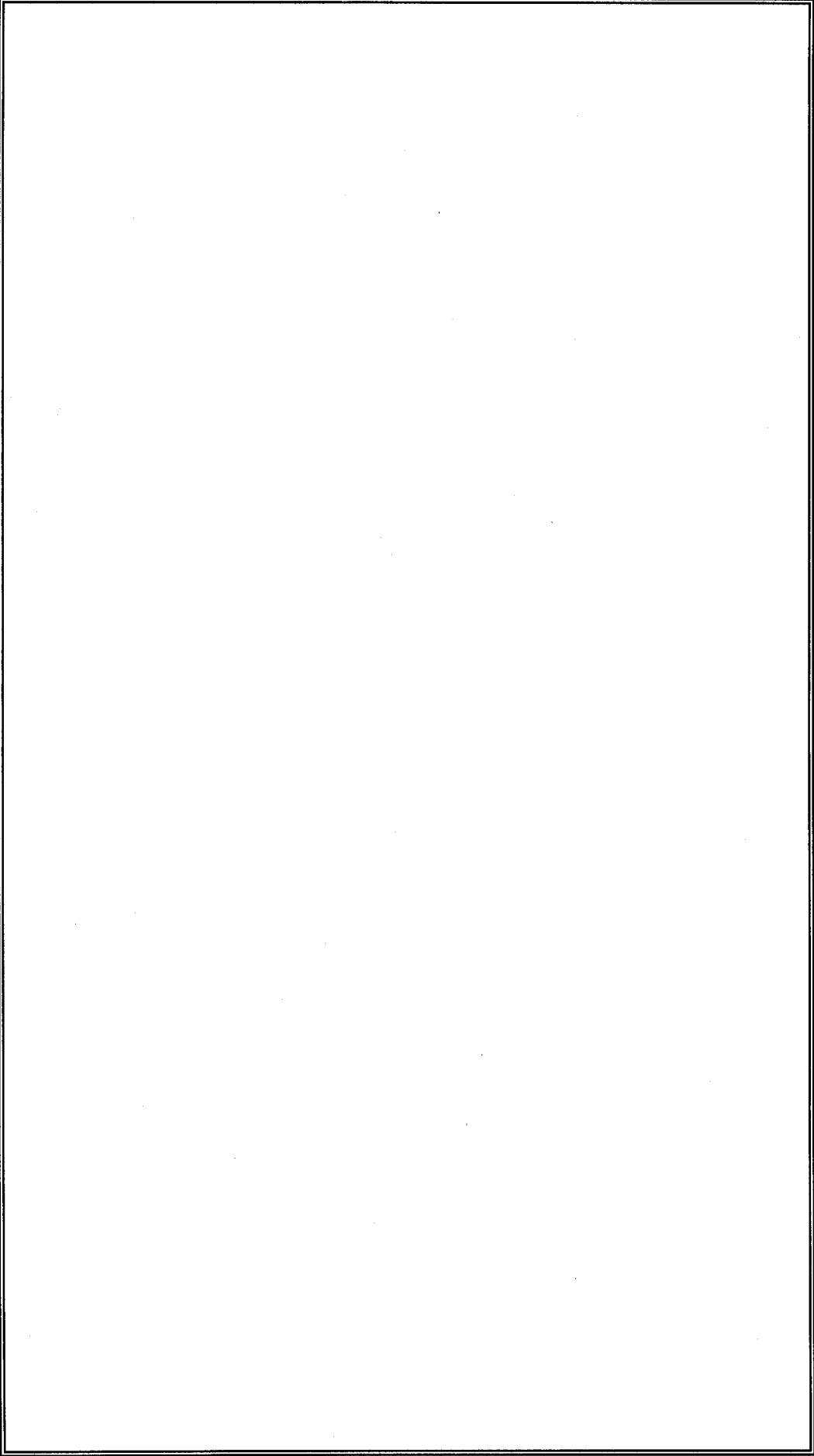
4. Enter the code from the list below that best describes your organization.

<input type="checkbox"/> C = CORPORATION	<input type="checkbox"/> I = INDIVIDUAL	<input type="checkbox"/> P = PARTNERSHIP
<input type="checkbox"/> A = ASSOCIATION	<input type="checkbox"/> J = JOINT	<input type="checkbox"/> O = OTHER (Please Specify) _____

5. Enter your 4 digit County/Municipality Code for NJ Addresses ONLY.

<input style="width:25%;" type="text"/> <input style="width:25%;" type="text"/> <input style="width:25%;" type="text"/> <input style="width:25%;" type="text"/>

IMPORTANT: ANSWER ALL QUESTIONS (Please Print or Type Clearly)



Sign your name inside the width of the box with thick black marker (large & bold)

PRINT NAME: _____