

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**

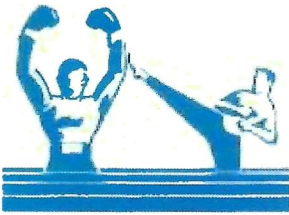
All application packets must be completed in full and received by the **Promoter** and/or **Matchmaker** no later than three (3) days prior to the event. Application packets will consist of:

- An application with signature page
- 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

No license will be issued until all requirements are met.

:RUH

H:\\Document Templates\\licensing procedures applicant for event and renewal.docx



State Athletic Control Board

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

TO: AMATEUR COMBATIVE SPORTS CONTESTANTS

RE: NEW JERSEY AMATEUR MIXED MARTIAL ARTS LICENSE APPLICATION

Enclosed are the annual requirements for application as licensed amateur MMA contestant in the State of New Jersey. **All contestants are advised to apply for licensure via the promoter, once you have been scheduled to compete at a New Jersey sanctioned event.**

To be licensed as an **Amateur MMA** contestant, you must submit the following to this office.

1. Completed Amateur License Application Forms
2. Amateur Mixed Martial Arts Contestant Form
3. Amateur Mixed Martial Arts Physical Form
4. Check or money order in the amount of \$5.00, payable to: *State Athletic Control Board*
5. A digital photo ID (driver's license or passport)
6. A headshot shot photo

**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 Amateur License that you receive will be effective for **Twelve (12)** months from date of issue.

To reduce the costs for 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:

Inspira Health Network  
Combatant Sports Medicine  
Imaging Center  
201 Tomlin Station Rd.  
Mullica Hill, NJ 08062  
Phone: 856-641-6377  
Fax: 856-453-1218  
Attn: Maximilian Halperin  
Email: halperinm@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.

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

LHruh  
Enclosure  
05.2022

**\*\*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, NJ 08625-0180

Telephone: 609.292.0317 Office Fax: 609.341.5038

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

AMATEUR CONTESTANT	AMATEUR MANAGER	AMATEUR SECOND
MMA <input type="checkbox"/> \$5	MMA <input type="checkbox"/> \$25	MMA <input type="checkbox"/> \$25
Kickboxer <input type="checkbox"/> \$5	Kickboxer <input type="checkbox"/> \$25	Kickboxer <input type="checkbox"/> \$25
Muay Thai <input type="checkbox"/> \$5	Muay Thai <input type="checkbox"/> \$25	Muay Thai <input type="checkbox"/> \$25
<b>LAST NAME</b> print clearly in space below	<b>FIRST NAME</b> print clearly in space below	<b>MIDDLE NAME</b> print clearly in space below

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? <b>YES</b> <b>NO</b> If yes, explain:
Social Security No. ____/____/____	Height _____ Weight _____	Are you presently on any suspension list? <b>YES</b> <b>NO</b> If yes, please explain:
Country of Citizenship:	Place of Birth (city/state)	Have you ever been disqualified in any contest or disciplined for your actions during a contest? <b>YES</b> <b>NO</b> If yes, please explain:
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 - Mixed Martial Artist, Kickboxer & Muay Thai Contestants 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 & Address of Gym or Club where you trained: _____	
Do you have a Manager and/or Trainer? <b>YES</b> <b>NO</b> If yes, provide name (s)	
Manager Name: _____	Address: _____ Contact# _____
Trainer Name: _____	Address: _____ Contact# _____



**SECTION II (continued) \*\*Fighters Only\*\* Communicable Bodily Fluid Virus High-Risk Pre-fight Medical 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 (Managers, Seconds & Self-Managed Boxers Only) If you are a boxer without a manager, please complete this section. Please Print**List names of fighter(s) which you currently manage or second: *(Write self if you are a boxer)* \_\_\_\_\_

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

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: \_\_\_\_\_

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

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

**STATE OF NEW JERSEY  
STATE ATHLETIC CONTROL BOARD  
AMATEUR MIXED MARTIAL ARTS CONTESTANT FORM**  
(Please fill form out completely)

Date of Event: \_\_\_\_/\_\_\_\_/\_\_\_\_ Name of Event: \_\_\_\_\_  
Fighter Full Legal Name: \_\_\_\_\_  
Alias: \_\_\_\_\_  
Fighter Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Fighter Home Address: \_\_\_\_\_  
Fighter Phone Number: \_\_\_\_\_  
Fighter School Affiliation: \_\_\_\_\_

**FIGHTER CERTIFICATION:** I hereby certify that I am skilled enough, healthy and ready to compete in this Amateur Mixed Martial Arts competition. I further certify that I have not engaged in any Professional or Professional Rules Style Mixed Martial Arts competitions and that I have not been paid to compete.

Trainer Name: \_\_\_\_\_  
Trainer School: \_\_\_\_\_  
School Address: \_\_\_\_\_  
Trainer Contact Number: \_\_\_\_\_

**TRAINER CERTIFICATION:** I, \_\_\_\_\_, hereby certify that Fighter \_\_\_\_\_ is skilled enough, healthy and ready to compete in this Amateur Mixed Martial Arts competition. I further certify that Fighter has not engaged in any Professional or Professional Rules Style Amateur Mixed Martial Arts competitions and has not been paid to compete.

01) Has Fighter ever competed in a Combative Sports contest in another State? If yes, please list all dates and City/State: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

02) Has Fighter ever competed in a Combative Sports contest in the State of Delaware? If yes, please list all dates and City: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

03) Are you under a Medical or Disciplinary Suspension from any Athletic Commission or Sanctioning Organization? If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

04) What was the date and result of your last Amateur Mixed Martial Arts contest?: \_\_\_\_\_  
\_\_\_\_\_



**STATE OF NEW JERSEY  
STATE ATHLETIC CONTROL BOARD  
AMATEUR MIXED MARTIAL ARTS CONTESTANT FORM**

The Contestant understands that by participating in this contest of unarmed combat, that the Contestant is engaging in an abnormally dangerous activity which subjects Contestant to a risk of severe injury or death. The Contestant, in full knowledge of the risks, nonetheless, agrees to enter into this agreement and hereby waives any claim that the Contestant or Contestant's heirs may have against the Athletic Control Board (hereinafter "SACB") or the State of New Jersey as the result of any injury the Contestant may suffer as a result of Contestant's participation in this contest. I have read and understand the above.

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

The parties, jointly and severally hereby discharge, release, indemnify and hold harmless the SACB, the SACB's individual members and employees, bout officials and agents, and the State of New Jersey in their individual, personal and representative capacities against any and all claims, suits, actions, debts and judgments, in law or equity, brought against the parties named in this agreement due to this agreement and all other matters relating hereto.

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

The contest shall be conducted in accordance with the laws of the State of New Jersey and in accordance with the statutes, rules, regulations and policies of the SACB which are hereby made part of this agreement.

It is understood and agreed that the rights and obligations of the parties hereto shall be governed by and construed in accordance with the laws of the State of New Jersey.

I, the undersigned, hereby declare that I have read this Application and that all answers to the questions are true and complete. I understand that any misrepresentation or failure to answer shall constitute grounds for any applicable legal penalties.

FIGHTER SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**NEW JERSEY STATE ATHLETIC CONTROL BOARD - Amateur Mixed Martial Arts Physical Form**  
(To Be Completed by Physician - physical must be taken within 45 days of each event - NJSACB fax is 609-292-3756)

Contestant Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

I certify that I have examined the above contestant on \_\_\_\_\_ and have found him/her to be medically cleared to engage in an Amateur Mixed Martial Arts competition on \_\_\_\_\_

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

Physician Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

**CONTESTANT INFORMATION:** Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Abdominal Palpation: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Hernias or Viscero-megaly: \_\_\_\_\_

Blood Pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_ Temperature: \_\_\_\_\_ Blood Type: \_\_\_\_\_

Allergies: \_\_\_\_\_ Tests: \_\_\_\_\_

Medications: \_\_\_\_\_ **TENDON REFLEXES:** \_\_\_\_\_

**EYE EXAMINATION:** \_\_\_\_\_ Knee Jerk: \_\_\_\_\_

No retinopathies or cataracts: \_\_\_\_\_ Babinski: \_\_\_\_\_

Wears contact lenses: \_\_\_\_\_ Rhomberg: \_\_\_\_\_

**EXAMINATION:** Finger to nose: \_\_\_\_\_

**UPPER EXTREMITIES:** \_\_\_\_\_

Ears - Otoloscopy: \_\_\_\_\_ Hands: \_\_\_\_\_

Mouth Pharynx: \_\_\_\_\_ Wrist: \_\_\_\_\_

Adenopathys: \_\_\_\_\_ Elbows: \_\_\_\_\_

Lower Extremities: \_\_\_\_\_ Shoulder Girdle: \_\_\_\_\_

Skin (Open or Superficial lesions): \_\_\_\_\_

Lungs: \_\_\_\_\_

Heart: \_\_\_\_\_ Any indications of active renal disease: \_\_\_\_\_

**PHYSICAL HISTORY:** \_\_\_\_\_

Chest Pains: \_\_\_\_\_

Fainting Spells: \_\_\_\_\_

Spitting of Blood: \_\_\_\_\_

Shortness of Breath: \_\_\_\_\_

Frequent Headaches: \_\_\_\_\_

Convulsions: \_\_\_\_\_

Head Injury: \_\_\_\_\_

Operations: \_\_\_\_\_

Diabetes: \_\_\_\_\_

Unconsciousness from training or competing: \_\_\_\_\_

Unconsciousness from any other sport or any other reason: \_\_\_\_\_

**FOR WOMEN:** \_\_\_\_\_

Pregnancy Test: \_\_\_\_\_

Breast Exam: \_\_\_\_\_

Gynecological Exam: \_\_\_\_\_

**COMMENTS:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

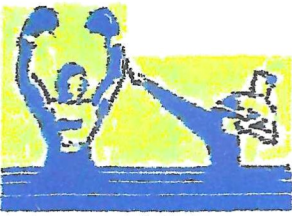
\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_





**State Athletic Control Board**

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

**RELEASE AUTHORIZATION**  
**(Contestants)**

I hereby authorize the release of my medical records to the New Jersey State Athletic Control Board. I understand that I may be waiving privacy protections afforded to me under the H.I.P.A.A. and any other applicable laws. My signature constitutes my consent to release my medical information to the New Jersey State Athletic Control Board.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**LPS**

New Jersey Department of Law & Public Safety

*New Jersey Is An Equal Opportunity Employer*