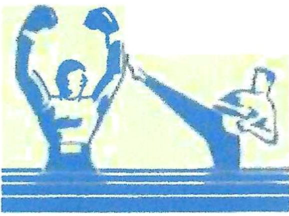


State Athletic Control Board

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

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: 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. **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 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
11. A digital photo ID (driver's license or passport)
12. 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 Boxer 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

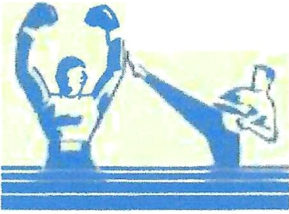
Applicants are reminded: You are subjected to the requirements of the State Athletic Control Board rules, provided by Chapter 46 of the New Jersey Administrative Code.

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:RUH:ruh
Enclosure
05.2022



State Athletic Control Board

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

Attention All Boxers, Kickboxers, Mixed Martial Artists & MuayThai Contestants

Pre-Fight Medical Questionnaire

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 the New Jersey State Athletic Control Board 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/ruh
Revised: May 2022

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 Office email address: SACBlicensing@njoag.gov

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

	CONTESTANT	MANAGER	SECOND	ANNOUNCER ❑ $100
Last Name:	Boxer ❑ $5	Boxing ❑ $25	Boxing ❑ $25	TIMEKEEPER ❑ $100
	Kickboxer ❑ $5	Kickboxer ❑ $25	Kickboxer ❑ $25	INSPECTOR ❑ $0
First Name:	MMA ❑ $5	MMA ❑ $25	MMA ❑ $25	PHYSICIAN ❑ $0
	REFEREE	**JUDGE**	**PROMOTER**	**MATCHMAKER**
	Boxing ❑ $100	Boxing ❑ $100	Boxing ❑ $300	Boxing ❑ $100
Middle Name:	Kickboxing ❑ $100	Kickboxing ❑ $100	Kickboxing ❑ $300	Kickboxing ❑ $100
	MMA ❑ $100	MMA ❑ $100	MMA ❑ $300	MMA ❑ $100
	Amateur MMA ❑ $100 Am Muay Thai ❑ $100	Amateur MMA ❑ 100 Am Muay Thai ❑$100	Amateur MMA ❑ $300 Am Muay Thai ❑ $300	Amateur MMA ❑ $100 Am Muay Thai ❑ $100
AKA or Alias:				

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

Date of Birth: ______/______/______	Sex: **Male** **Female**	Have you ever been convicted of a crime? **YES** **NO** If yes, explain
Social Security No. ______/______/______	**Height** **Weight** ______ ______	Are you presently on any suspension list? **YES** **NO** 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? **YES** **NO** If yes, please explain:
E-Mail:		Has any license you've held been revoked? **YES** **NO** 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 - Boxers, Kickboxers & Mixed Martial Artists Only - Please Print

Have you ever been hospitalized due to an injury suffered in any contest? If YES, please explain **YES** **NO**	Do you have any current medical conditions? **YES** **NO** If YES, please explain.

Have you had amateur experience? **YES** **NO** Amateur Record: __________ Number of Fights: __________

Submission Grappling Record __________

Name & Address of Gym or Club where you train: __________

Do you have a **Manager** and/or **Trainer**? **YES** **NO** If yes, provide name

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.

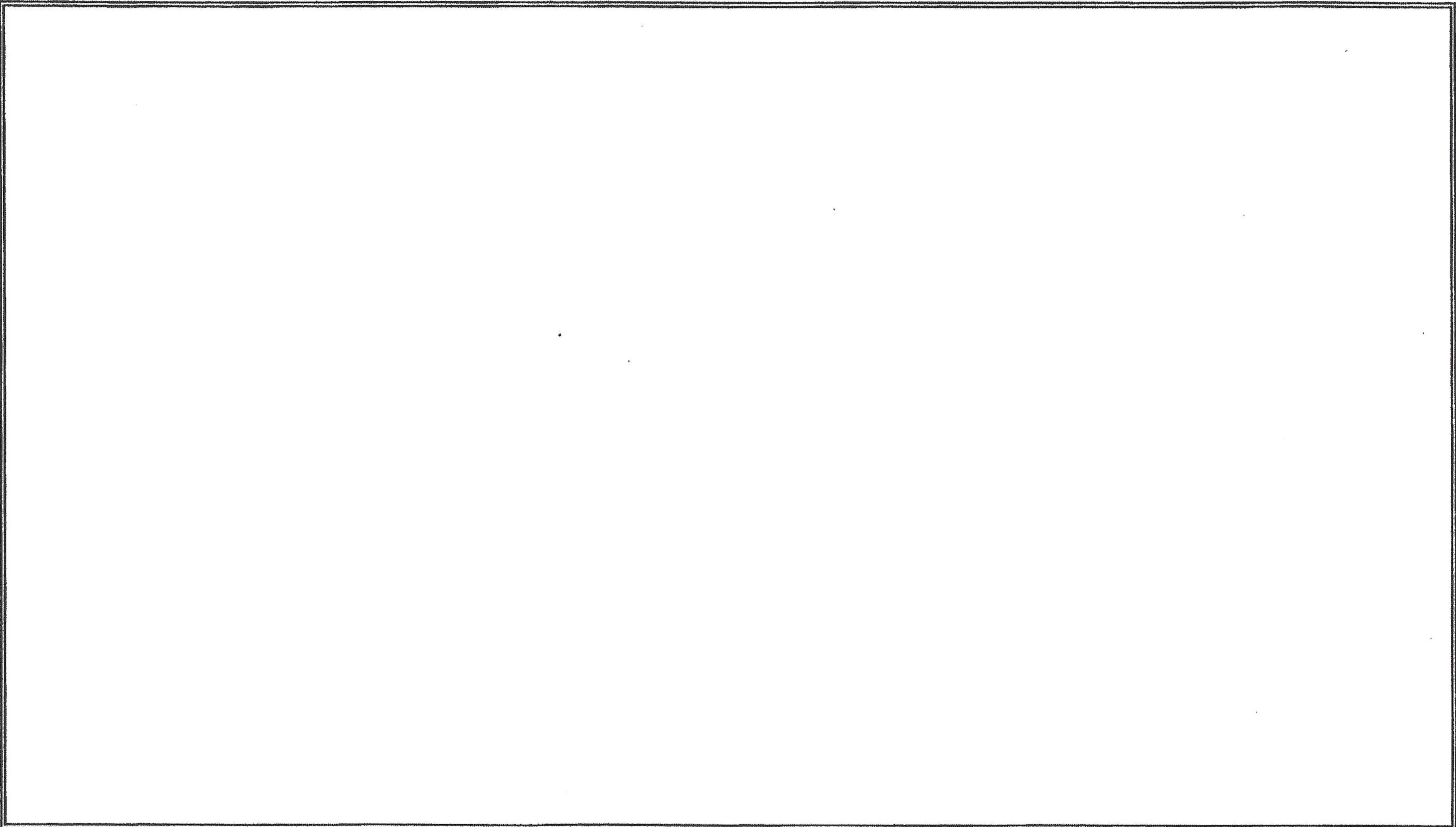
I THE UNDERSIGNED STATE THAT A PHOTOSTATIC OF THIS AUTHORIZATION WILL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

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: ______________________________________

NEW JERSEY STATE ATHLETIC CONTROL BOARD

PROFESSIONAL COMBATIVE SPORTS CONTESTANT PHYSICAL EXAMINATION FORM

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 a combative sports 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

____

Cranial Nerves:

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Bicep Jerks:

____

Brudzinski:

____

UPPER EXTREMITIES:

Hands:

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Wrist:

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____

Elbows:

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____

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:

____

Unconscious from training or competing:

____

Unconscious from any other sport: or any other reason:________________

____

Sickle Cell Disease:______________

Infectious Disease:______________

FOR WOMEN:

Pregnancy Exam:______________

Breast Exam:______________

Gynecological Exam:______________

PHYSICIAN COMMENTS:______________

____

____

____

Rev. March 2022

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NEW JERSEY STATE ATHLETIC CONTROL BOARD

DILATED EYE EXAMINATION MUST BE PERFORMED BY AN OPHTHALMOLOGIST

Contestant Name: ______________________________

Street Address: ______________________ City______________________ State__________ Zip__________

Phone: ______________________ Date of Birth: ______________

EYES	RIGHT	LEFT
Distant Vision:		
Light Reflex:		
Accommodation Reflex:		
Fundi:		
Cataracts:		
Uncorrected Vision::		

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 combative sports 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) ______________________________

New Jersey State Athletic Control Board
License Medical Requirements

1. **Computerized Axial Tomography Exam (CAT Brain Scan) or MRI Brain Scan (without contrast):**
   Exam must be **dated within 3 years** of licensure/event

2. **Electrocardiogram (EKG):**
   Exam must be **dated within 6 months** of licensure/event

3. **Ophthalmological Dilation (Eye):**
   Exam must be **dated within 6 months** of licensure/event
   (exam must be performed by a certified Ophthalmologist)

4. **Comprehensive History and Physical Examination:**
   Exam must be **dated within 6 months** of licensure/event

5. **CBC** (Complete Blood Count**)** which includes Hemaglobin & Hematocrit
   PT (Prothrombin Time) **&** **PTT** (Partial Thromboplastin) for Bleeding and Coagulation
   These exams will be required for a contestants 1st appearance to compete in New Jersey. However, the NJSACB medical personnel may request the test at anytime they deem necessary. Exam must be **dated within 6 months** of licensure/event.

6. **HIV Test:**
   Not required to obtain a license, however, to compete in an event, test must be **dated within 6 months** of event

7. **Hepatitis B Surface AG**
   Hepatitis C AB testing (not vaccination)
   Not required to obtain a license, however, to compete in an event, tests must be **dated within 6 months** of event

8. **Serum Pregnancy Test:**
   Test must be **dated within 30 days** of licensure/event
   This test must be **repeated within 30 days of each event**

9. **Annual Physical/Clinical Gynecological and Breast Exams for Women:**
   Test must be **dated within 30 days** of licensure/event

All participants are required to have the New Jersey State Athletic Control Board Physical Examination Form completed and signed by all physicians administrating the necessary examinations. The original documents must be turned into the New Jersey State Athletic Control Board Commissioner along with all other required medical examination documentation.

New Jersey State Athletic Control Board
P.O. Box 180
Trenton, New Jersey 08625.

If you should have any questions, please contact this office at 609-292-0317.

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Rev. 3/9/22

P.O Box 180 • Trenton, NJ 08625-0180 • (609) 292-0

TO: PROFESSIONAL COMBATIVE SPORTS CONTESTANTS

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

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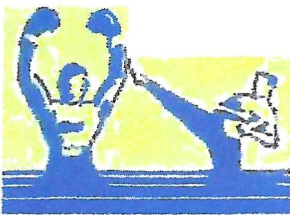
5. Complete Blood Count (CBC) and Bleeding & Coagulation (PT/PTT Pro-Time)-(dated within 6 months of licensure)
6. Original EKG report, read by a physician (dated within 6 months of licensure)
7. Original CT/MRI Brain SCAN report (without contrast), read by a physician (dated within 3 years of licensure/event)
8. Original EYE examination by an ophthalmologist - opthalmological 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

2. Physical Exam - $85
3. & 4. Blood Trio - $120
5. CBC & PT/PTT - $105
6. EKG - $50
7. CT - $280
8. Eye (MD/DO, not OD) - $75
(9. Female Only - $25)

TOTAL FOR NJ MEDICALS - $715

These prices are for cash or card (we are not able to take insurance with combatant physicals). Bill must be paid at the time of visit.



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