

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.

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:

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

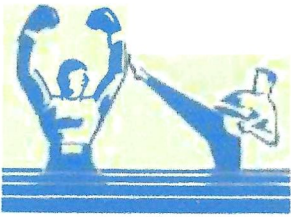
Applicants are reminded: You are subjected to the requirements of the State Athletic Control Board rules, provided by Chapter 46 of the New Jersey Administrative Code.

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



Attention All Boxers, Kickboxers, Mixed Martial Artists & MuayThai Contestants
Pre-Fight Medicals 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.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 Office email address: SACBlicensing@njoag.gov

SECTION I - All Applicants Complete

Check (✓) or circle Type(s) of License

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

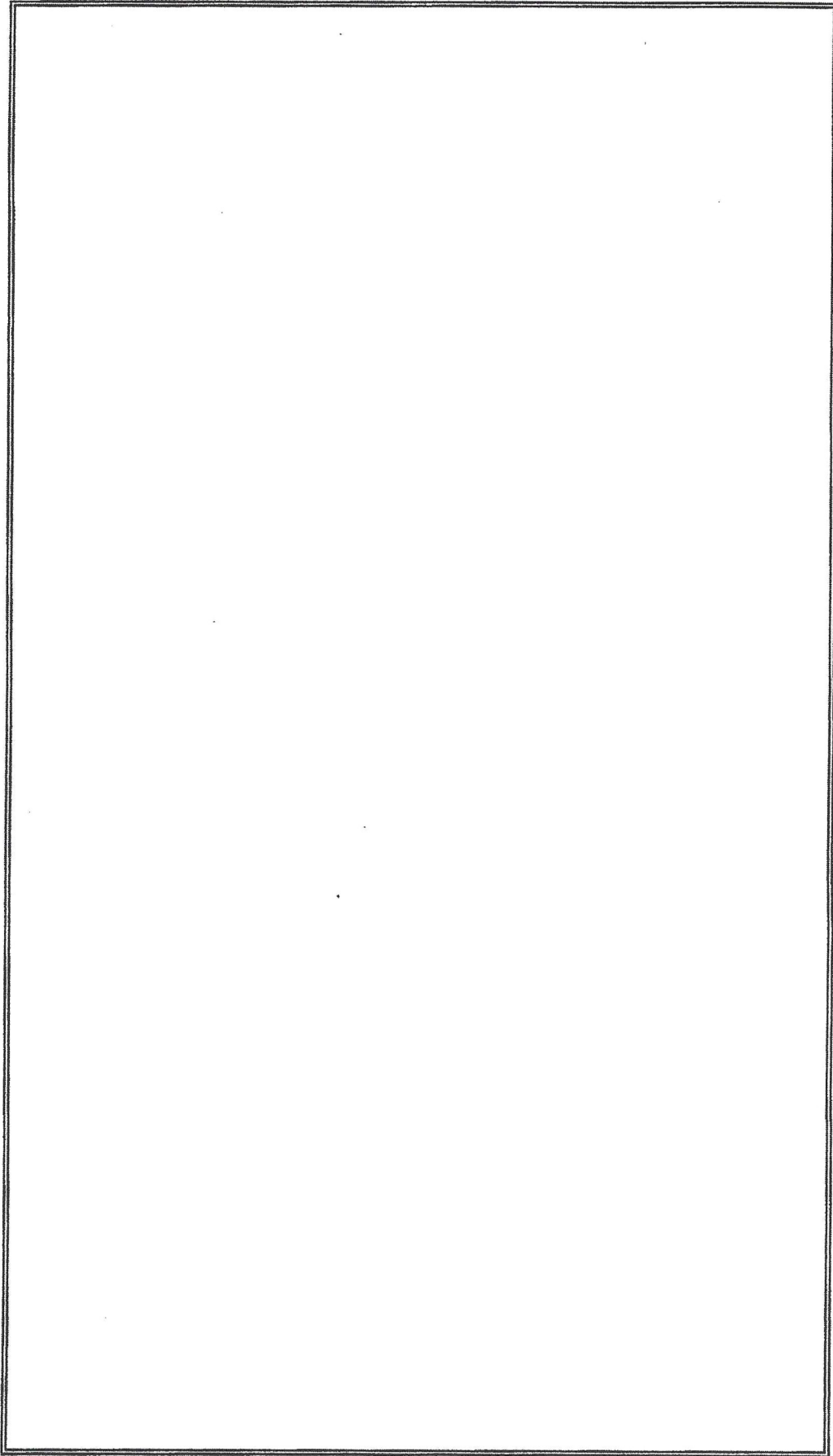
I THE UNDERSIGNED STATE THAT A PHOTOSTATIC OF THIS AUTHORIZATION WILL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

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:

Bicep Jerks:

Brudzinski:

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:

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:

NEW JERSEY STATE ATHLETIC CONTROL BOARD

DILATED EYE EXAMINATION MUST BE PERFORMED BY AN OPTHALMOLOGIST

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.

TO: PROFESSIONAL COMBATIVE SPORTS CONTESTANTS

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

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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.