New York State
Athletic Commission

New York State
Department of State
State Athletic Commission
123 William Street
New York, NY 10038-3804
Telephone: (212) 417-5700

PRE-FIGHT CARDIOLOGY CLEARANCE FORM

*For cardiology clearance to fight in New York State, a physician **Board Certified in Cardiology** should complete this form in its **entirety**.*

LAST NAME FIRST NAME DATE OF BIRTH

STREET ADDRESS CITY STATE ZIP CODE

HISTORY

Have you ever fainted during or after exercise? **YES** **NO**

If yes, please explain: ______________________________

How many bouts have you had since your last EKG? ____________

How many rounds have you fought since your last EKG? ____________

Have you ever had chest pain during or after exercise? **YES** **NO**

If yes, please explain: ______________________________

Do you get tired more quickly than your friends do during exercise? **YES** **NO**

If yes, please explain: ______________________________

Have you ever had racing of your heart or skipped heartbeats? **YES** **NO**

If yes, please explain: ______________________________

Have you been told you had high blood pressure or high cholesterol? **YES** **NO**

If yes, please explain: ______________________________

Have you ever been told you have a heart murmur? **YES** **NO**

If yes, please explain: ______________________________

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LAST NAME　　FIRST NAME　　DATE OF BIRTH

Has any family member or relative died of heart problems or of sudden death before age 50? **YES** **NO**

If yes, please explain: ______________________________

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Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the past month? **YES** **NO**

If yes, please explain: ______________________________

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Has a physician ever denied or restricted your participation in sports for any heart problems? **YES** **NO**

If yes, please explain: ______________________________

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EKG Review:

Date of EKG Report: ____________　　Date of this report: ____________

Does this athlete have Normal Sinus Rhythm? **YES** **NO**

If no, please explain: ______________________________

Is the EKG report within normal limits? **YES** **NO**

If no, please explain: ______________________________

Based on your personal medical opinion and considering NYSAC rules, is this applicant **cardiologically cleared** to be licensed to compete and participate in combative sports? **YES** **NO**

If no, please explain: ______________________________

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Is further referral or additional examinations necessary or recommended? **YES** **NO**

If yes, please explain: ______________________________

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LICENSED PHYSICIAN'S NAME (PRINT)　　MEDICAL LICENSE NO. / STATE OF ISSUE

____
ADDRESS / CITY / STATE / ZIP CODE　　TELEPHONE NO. DATE / TIME

____
PHYSICIAN'S SIGNATURE

____
APPLICANT NAME (PRINT)　　APPLICANT SIGNATURE