|  |  |  |  |
| --- | --- | --- | --- |
| **Applicant** | Name of Applicant: |  | Age Date of Birth (YR/MM/DD) |
| Address: |  | Postal Code: |
| **History of Previous Illness, Accident or Operation** |  |
|  |
|  |
|  |
|  |
|  |
| **Hearing** | Any Impairment? |  | * Yes No
 |
| **Vision** | Pupils equal?React to light and accommodation? Funduscopic examination normal? |  | * Yes No
* Yes No
* Yes No
 |
| **Far Vision**Uncorrected Corrected | R/20/20 | L/20/20 |  | **Near Vision** Read Regular Newsprint at 18R LUncorrected Corrected  |
| Is there any abnormality of color vision? Is there any abnormality of visual fields? |  | * Yes No
 |
| **Mouth** | Any disease of the mouth, throat, nose and ears? |  | * Yes No
 |
| **Glands** | Any enlargement of the thyroid or lymphatic glands? |  | * Yes No
 |
| **Respiratory** | Any evidence of acute or chronic respiratory disease? |  | * Yes No
 |
| **Blood Pressure** | Systolic Diastolic | Initial   |  | Additional   |  | **Repeat at End of Examination if Over****140/90** |
| **Heart** | Heart Rate, counted at the apex for one minute Any disturbance of cardiac rhythm? Yes No Any indication of the disease of the heart or blood vessel? Yes No |
| **Abdomen** | Does examination reveal any abnormality? | * Yes
 | * No (if
 | ‘yes’ please describe)  |
| **Hernia** | Is there a hernia evident? |  | * Yes No
 |
| **Reflexes** | Are knee jerks present and equal? |  | * Yes No
 |
| **Nerves** | Any disorders of the nervous system present? |  | * Yes No
 |
| **Alcohol And Drugs** | Is there evidence of the use of alcoholic beverages? Is there evidence of the use of stimulating drugs? |  | * Yes No
* Yes No
 |

|  |  |
| --- | --- |
| **General** | Is there any evidence of any condition or disorder not covered by theabove information that requires additional examination or that would Yes No prevent the applicant from refereeing in a safe and effective manner? |
| **Certification** | This is to certify that the above-named referee was examined by me and that as a result of the examination,is considered **Fit** **Unfit** to referee |
| Date: Name: Address: Signature: Phone: (Medical Examiner) |
|  | **First Time Applicants*** Complete exam as per this form
* ECG
* Chest X-ray
* Urinalysis
* Complete blood count (Profile and Differential)
* Yearly exam applicable up to 30 + urine
* Test and complete blood count

**For Relicense Yearly**over 30 years to 40 years* Complete exam yearly
* ECG every 5 years
* Chest X-ray every 5 years
* Urinalysis yearly
* Complete blood count yearly

**For Relicense Over 40 Years*** ECG every 2 Years
* Chest X-ray every 2 years
* Urinalysis yearly
* Complete blood count yearly
 | **Space For Additional Information** |  |
| **The Nova Scotia Combat Sports Authority reserves the right to request a medical examination by the Authority Medical Advisor or a specialist to be designated by him in the event he may believe that such referee may have a medical condition which could interfere with the safe and effective discharge of duty as a referee.** |