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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Applicant** | Name of Applicant: | | | | |  | Age Date of Birth (YR/MM/DD) |
| Address: | | | | |  | Postal Code: |
| **History of Previous Illness, Accident or Operation** |  | | | | | | |
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| **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 18  R L  Uncorrected 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 |

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| **General** | | Is there any evidence of any condition or disorder not covered by the  above 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.** | | |