REFEREE PHYSICAL EXAMINATION REPORT

Access this form via website at: hawaii.gov/dcca/pvl

HAWAII MMA PROGRAM
P.O. BOX 3469
HONOLULU, HI 96801
TELEPHONE: (808) 586-2701
FAX: (808) 586-2874

Name (First, Middle, Last) _____ Phone No. _____ Date of Birth _____

Address (Include Apt. No., City, State and Zip Code) _____

PHYSICAL HISTORY: Has applicant ever had any of the following conditions:

- ☐ Fainting spells
- ☐ Rupture (hernia)
- ☐ Chest pains
- ☐ Operations
- ☐ Shortness of breath
- ☐ Swollen joints
- ☐ Rheumatism
- ☐ Diabetes
- ☐ Frequent headaches
- ☐ Convulsions (fits)
- ☐ Chronic cough
- ☐ Bleeding Disorder
- ☐ Spitting of blood
- ☐ Cerebral hemorrhage or any other serious head injury

If "yes", explain: _____

EXAMINATION

General appearance _____ Height _____ Weight _____ Temperature _____

Disabling scars _____ Mouth _____ Teeth _____ Tonsils _____ Neck _____

Pulse at rest _____ Pulse after 100 hops _____ Pulse 2 minutes later _____

Blood pressure at rest _____ Blood pressure after 100 hops _____ Blood pressure 2 minutes later _____

Enlarged glands: ☐ Yes ☐ No Goiter: ☐ Yes ☐ No

Heart: Pulse rhythm ☐ Regular ☐ Irregular Apical impulse ☐ Heavy ☐ Normal
Enlargement ☐ Yes ☐ No Murmurs ☐ Yes ☐ No

Lungs: Rales ☐ Yes ☐ No Ears _____ Nose _____

Abdomen: Enlargement of liver ☐ Yes ☐ No Enlargement of Spleen ☐ Yes ☐ No

Genitalia: Discharge _____ ☐ Yes ☐ No Varicocele _____ ☐ Yes ☐ No
Hernia ☐ Yes ☐ No Femoral ☐ Inguinal ☐ Ventral ☐

Testicles: Normal ☐ Yes ☐ No Remarks: _____

Reflexes: Pupils _____ Romberg _____
Knee jerks _____ Babinski _____

Skin: Rash _____ Boils _____ Any other unhealed wounds: _____

REMARKS: _____

(CONTINUED ON PAGE 2)

Print Name of Applicant: _____ Date: _____

YOU MUST GO TO AN OPHTHALMOLOGIST OR AN OPTOMETRIST FOR AN EYE EXAMINATION

EXAMINING PHYSICIAN: THE FOLLOWING SECTION MUST BE COMPLETED.
I have examined the above named subject and find him in:

☐ **satisfactory** ☐ **unsatisfactory**

condition to be licensed as a professional REFEREE.

_____ _____
LICENSED PHYSICIAN'S NAME (Please Print) PHYSICIAN'S LICENSE NO.

_____ _____
PHYSICIAN'S SIGNATURE DATE

_____ _____
STREET ADDRESS CITY STATE ZIP TELEPHONE NO.

I declare under penalty of perjury, that the foregoing information is true & correct; further, I realize that any intentional misrepresentation may result in disciplinary action.

_____ _____
SIGNATURE OF APPLICANT DATE

Print Form

This material can be made available for individuals with special needs. Please call the Licensing Branch Manager at (808) 586-3000 to submit your request.