



## South Dakota Athletic Commission

P.O. Box 340, 1351 N. Harrison Ave., Pierre, SD 57501-0340

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### Boxer/Kickboxer/Mixed Martial Artist Registration Application

**Instructions:**

- 1) A completed Application and \$50 fee must be submitted.
- 2) Acceptable photo identification must accompany the Application.
- 3) A Completed Release and Waiver of Liability, Assumption of the Risk and Indemnity Agreement and Consent to Medical Treatment by the Applicant must be submitted with the Application.
- 4) Verification of a physical within the previous 12 months from a licensed physician.
- 5) Verification of a dilated eye exam within the previous 12 months from a licensed optometrist or ophthalmologist.
- 6) Proof the applicant has been tested and is negative for HIV, Hepatitis B and Hepatitis C.
- 7) Verification of License or Registration in any other jurisdictions (a copy of license or registration or license or registration numbers must be provided with the Application).

Legal Name		Professional/Stage Name		
Address		City	State	Zip Code
Telephone Number	Date of Birth	Social Security Number		Federal ID Number ( <i>Boxers</i> )
Height	Exact Weight at Application		Weight/Division	
Eye Color	Hair Color	Distinguishing Marks		
Name of Emergency Contact		Telephone Number of Emergency Contact		

**Please provide answers to the following questions. If indicated, please provide the appropriate follow up information or documentation.**

1. Are you currently licensed or registered to compete in any other jurisdictions (state or tribal)?	Yes	No
If yes, list state(s) and/or jurisdiction(s) _____		
2. Have you ever been denied a license or registration to compete by any other jurisdiction (state or tribal)?	Yes	No
If yes, list state(s) and/or jurisdiction(s) _____		
3. Have you ever had a license or registration to compete revoked or suspended by any other jurisdiction (state or tribal)?	Yes	No
If yes, list state(s) and/or jurisdiction(s) _____		
4. Do you have any type of medical insurance?	Yes	No
If yes, please provide the Carrier name, address and telephone number _____		

Name of Manager	Name of Trainer	Name of Club where you train		
Overall Record as a Professional		Overall Record as an Amateur		
Date of Last Fight	Location of Last Fight	Result of Last Fight		
<b>Medical Information/Examinations</b>				
<b>Date of last complete physical examination</b> <i>(Including head and chest y-rays, E.K.G. E.E.G. CAT SCAN, B/P, Hernia, Blood Chemical Analysis and Urinalysis. (Be prepared to provide records of exam if requested))</i>		Month	Day	Year
Physician who performed complete physical examination		Did the physician clear you to compete in a boxing, kickboxing or mixed martial arts competition? <p style="text-align: right;"><b>Yes      No</b></p>		
Date of last dilated eye exam		Month	Day	Year
Optometrist or ophthalmologist who performed complete physical examination		Did the optometrist or ophthalmologist clear you to compete in a boxing, kickboxing or mixed martial arts competition? <p style="text-align: right;"><b>Yes      No</b></p>		
Have you ever suffered a cerebral hemorrhage or a serious bodily injury, either due to competing or at any other time? <p style="text-align: right;"><b>Yes      No</b></p>		Do you understand that contestants under the jurisdiction of the Commission are subject to random drug testing for prohibited drugs, stimulants or nonprescription preparations? <p style="text-align: right;"><b>Yes      No</b></p>		

*BY MY SIGNATURE BELOW, I VERIFY, UNDER PENALTY OF PERJURY, THAT I AM THE PERSON COMPLETING THIS APPLICATION AND THAT ALL INFORMATION SUBMITTED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND THAT FALSE OR INCORRECT INFORMATION, OMISSIONS, INACCURACIES OR FAILURES TO MAKE FULL DISCLOSURE MAY RESULT IN THE CANCELLATION OR DENIAL OF A REGISTRATION ISSUED PURSUANT TO THIS APPLICATION AND MAY BE SUBJECT TO CIVIL AND CRIMINAL PROCEEDINGS. FURTHERMORE, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THAT I AM RESPONSIBLE FOR COMPLIANCE WITH SDCL CHAPTER 42-12 AND ARSD ARTICLE 20:81 IN THE ROLE(S) I AM SEEKING REGISTRATION FOR AND AM AWARE OF ALL SAID RESPONSIBILITIES AND REQUIREMENTS AND AGREE TO ABIDE BY ALL SAID RESPONSIBILITIES AND REQUIREMENTS. I FURTHER AGREE TO HOLD THE SOUTH DAKOTA ATHLETIC COMMISSION HARMLESS FOR ANY INJURY OR DEATH THAT MAY OCCUR AS A RESULT OF PARTICIPATING IN ANY COMPETITION.*

**To Be Signed in the Presence of a Notary Public**

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

State of \_\_\_\_\_

County of \_\_\_\_\_

On this \_\_\_\_ Day of \_\_\_\_, 20 \_\_\_\_, the above applicant personally appeared, known to me or satisfactorily proven to be the same person whose name is subscribed to the written instrument, and acknowledged that he/she executed the same for the purposes therein contained. In witness whereof, I have hereunto set my hand and official seal.

(SEAL)

\_\_\_\_\_, Notary Public

Notary Public Printed Name \_\_\_\_\_

My Commission Expires \_\_\_\_\_

**FOR COMMISSION USE ONLY**

Fee Received _____	Check _____	Date _____
Waiver Received _____		Date _____
Approval of Application _____		Date _____
Denial of Application _____		Date _____

**RELEASE AND WAIVER OF LIABILITY, ASSUMPTION OF THE RISK AND INDEMNITY AGREEMENT AND CONSENT TO MEDICAL TREATMENT**

By my signature below, I acknowledge that I am aware of, appreciate the character of, and voluntarily assume the risks involved in participating in

By my signature below, on behalf of myself, my heirs, next of kin, successors in interest, assigns, personal representatives, and agents, I hereby:

1. Waive any claim or cause of action against and release from liability the State of South Dakota, its officers, employees, and agents for any liability for injuries to my person or property resulting from my participation in the activity listed above;

2. Agree to indemnify and hold harmless the State of South Dakota, its officers, employees, and agents for any claims, causes of action, or liability to any other person arising from my participation in the activity listed above; and

3. Consent to receive any medical treatment deemed advisable during my participation in the activity listed above.

I HAVE READ THIS RELEASE AND WAIVER OF LIABILITY, ASSUMPTION OF THE RISK AND INDEMNITY AGREEMENT AND CONSENT TO MEDICAL TREATMENT, FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND HAVE SIGNED IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT, ASSURANCE, OR GUARANTEE BEING MADE TO ME AND INTEND MY SIGNATURE TO BE A COMPLETE AND UNCONDITIONAL RELEASE OF ALL LIABILITY TO THE GREATEST EXTENT ALLOWED BY LAW.

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Signature \_\_\_\_\_ Address \_\_\_\_\_

Date \_\_\_\_\_