



South Carolina Athletic Commission

P.O. Box 11329 • Columbia, SC 29211
Phone: 803-896-4571 • Fax: 803-896-4350
Contact.Athl@llr.sc.gov
www.llr.state.sc.us/POL/Athletic/



APPLICATION FOR REFEREE LICENSE

****All licenses are valid through December 31st of application year; regardless of application date****
Submit the following with your application to the Athletic Commission at the above address:

Wrestling Only Referee:

- Application Fee of \$50 payable to SC State Athletic Commission
A returned check fee of up to \$30, or an amount specified by law, may be accessed on all returned funds.
- Copy of Drivers License, State Issued ID or Passport
- Copy of Social Security card
- Medical Information Release
- Medical History Form/Physical Examination Form (must be submitted from Doctor's Office)

Boxing/OTSB/MMA/Kickboxing Referees:

- Application Fee of \$75 payable to SC State Athletic Commission
- Copy of Drivers License, State Issued ID or Passport
- Copy of social security card
- 3 Letters of Reference
- Medical Information Release
- Medical History Form/Physical Examination Form (must be submitted from Doctor's Office)

\$50 Wrestling Only Referee

\$75 Boxing, OTSB, MMA, Kickboxing, and/or Wrestling Referees

Primary Event Type (see below list): _____

Select all event types you will cover (not applicable for Wrestling Only Referee):

Boxing

OTSB

Kick Boxing

Wrestling

Mixed Martial Arts

APPLICANT INFORMATION:

Full Name: _____

Home Address: _____
(Street, City, State & Zip Code)

Mailing Address: _____
(If different than above)

Phone: _____ Email Address: _____

Date of Birth: _____ Age: _____ Social Security: _____

FOR COMMISSION USE ONLY	
State Lic #	_____
Federal ID #	_____
Weight	_____

Attach a valid photo ID that verifies your date of birth. (Driver's license, State ID or Passport)

PERSONAL HISTORY

1. Are you presently licensed or have you ever been licensed by any state or local athletic commission?
If yes, please list state(s): _____

Yes No
2. Have you ever been denied any type of professional or occupational license, including athletic license or permit in this state or jurisdiction?
(If yes, provide a detailed explanation on a separate sheet and remit with application.)

Yes No
3. Have you ever had any type of professional or occupational license or permit suspended, revoked, surrendered or have you ever been disciplined by the licensing authorities in this state or any other state or international jurisdiction?
(If yes, provide a detailed explanation on a separate sheet and remit with application.)

Yes No
4. Have you ever been convicted of a felony or other crime involving moral turpitude?
(If yes, you must provide a detailed explanation on a separate sheet and a statewide criminal background check from the state in which the incident occurred)

Yes No
5. Have you read and do you understand the South Carolina Athletic Law and the Rules, Regulations and Guidelines of the Commission?

Yes No

LETTERS OF REFERENCE:

(Excluding Wrestling Referees)

Submit written letters of reference from three people that describe your character and ability. Letters should include name, address and contact information.

Privacy Act Disclosure:

South Carolina Law requires that every individual who applies for an occupational or professional license provide a social security number for use in the establishment, enforcement and collection of child support obligations and for reporting to certain databanks established by law. Failure to provide your social security number for these mandatory purposes will result in the denial of your licensure application. Social security numbers may also be disclosed to other governmental regulatory agencies and for identification purposes to testing providers and organizations involved in professional regulation. Your social security number will not be released for any other purpose not provided for by law.

Privacy Act Disclosure Continued:

Other personal information collected by the Department for the licensing boards it administers is limited to such personal information as is necessary to fulfill a legitimate public purpose. The South Carolina Freedom of Information Act ensures that the public has a right to access appropriate records and information possessed by a government agency. Therefore, some personal information on the application may be subject to public scrutiny or release. The Department collects and disseminates personal information in compliance with The South Carolina Freedom of Information Act, the South Carolina Family Privacy Protection Act, and other applicable privacy laws and regulations. Additionally, the Department shares certain information on the application with other governmental agencies for various governmental purposes, including research and statistical services.

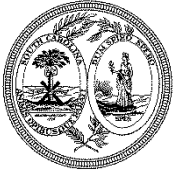
ATTESTATION AND SIGNATURE

I, _____, am the person described and identified, of good moral character, and
(Print Name)
the person named in all documents presented in support of this application. I certify that I have never been convicted of violating any Federal, State, Municipal or other law statute or ordinance, other than as disclosed as required within this application.

I certify that all statements contained herein are true and correct to the best of my knowledge. I further understand that false or incorrect information provided by me may result in the cancellation of any license issued pursuant to this application.

Signature of Applicant

Date



STATE OF SOUTH CAROLINA
DEPARTMENT OF LABOR, LICENSING AND REGULATION
VERIFICATION OF LAWFUL PRESENCE IN THE UNITED STATES
AFFIDAVIT OF ELIGIBILITY



Pursuant to Section 8-29-10, *et seq.* of the South Carolina Code of Laws (1976, as amended), the Department of Labor, Licensing and Regulation must verify that any person who applies for a South Carolina license is lawfully present in the United States. Complete and sign this affidavit of eligibility. The information provided is subject to verification.

Section A: LAWFUL PRESENCE in the United States.

The undersigned _____, of _____
(Print clearly First, Middle, and Last name) (Home Address, City, State, and Zip Code)

being first duly sworn deposes and states as follows:

Check only one box:

1. I am a United States citizen; or
2. I am a Legal Permanent Resident of the United States eighteen years of age or older; or
3. I am a Qualified Alien or non-immigrant under the Federal Immigration and Nationality Act, Public Law 82-414, eighteen years of age or older, and lawfully present in the United States.
4. Other: _____ Please submit any documentation that supports this status.

Date of Birth: _____

Alien Number: _____ I-94 Number: _____

(If you checked number 2, 3, or 4 you must attach a copy of your immigration documents. See Instruction sheet for a list of accepted immigration documents.)

Section B: ATTESTATION.

I understand that in accordance with section 8-29-10 of the South Carolina Code of Laws, a person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall, in addition to other sanctions imposed by this State or the United States, be guilty of a felony, and upon conviction must be fined and/or imprisoned for not more than 5 years (or both).

I understand that the representations made in this Affidavit shall apply through any license(s) or renewals issued, and that I shall have an affirmative duty to immediately advise the Department of Labor, Licensing and Regulation of any change of my immigration or citizenship status.

I swear and attest the information contained herein is true and correct to the best of my knowledge. I understand that under South Carolina law, providing false information is grounds for denial, suspension, or revocation of a license, certificate, registration or permit.

Signature of Affiant

SWORN to before me this _____ day of _____, 20____

Notary Signature

Notary Public for _____

My Commission Expires: _____

INSTRUCTION SHEET FOR COMPLETING AFFIDAVIT OF ELIGIBILITY

CHECK box 1:

If you are a United States Citizen by birth or naturalization

CHECK box 2:

If you are a Legal Permanent Resident and you are not a U.S. Citizen, but are residing in the U.S. under legally recognized and lawfully recorded permanent residence as an immigrant.

PROVIDE A COPY OF ALL IMMIGRATION DOCUMENTS.

CHECK box 3:

If you are a Qualified Alien. You are a Qualified Alien if you are:

An alien who is lawfully admitted for residence under the INA.

An alien who is granted asylum under Section 208 of the INA.

A refugee who is admitted to the United States under Section 207 of the INA.

An alien who is paroled into the United States under Section 212(d)(5) of the INA for a period of at least 1 year.

An alien whose deportation is being withheld under Section 243(h) of the INA (as in effect prior to April 1, 1997) or whose removal has been withheld under Section 241(b)(3).

An alien who is granted conditional entry pursuant to Section 203(a)(7) of the INA as in effect prior to April 1, 1980.

An alien who is a Cuban/Haitian Entrant as defined by Section 501(e) of the Refugee Education Assistance Act of 1980.

An alien who has been battered or subjected to extreme cruelty, or whose child or parent has been battered or subject to extreme cruelty.

PROVIDE A COPY OF ALL IMMIGRATION DOCUMENTS.

ACCEPTED IMMIGRATION DOCUMENTS:

Unexpired Reentry Permit (I-327)

Permanent Resident Card or Alien Registration Receipt Card With Photograph (I-551)

Unexpired Refugee Travel Document (I-571)

Unexpired Employment Authorization Card Which Contains a Photograph (I-766)

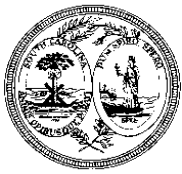
Machine Readable Immigrant Visa (with Temporary I-551 Language)

Temporary I-551 Stamp (on passport or I-94)

I-94 (Arrival/Departure Record) in Unexpired Foreign Passport

I-20 (Certificate of Eligibility for Nonimmigrant, F-1, Student Status)

DS2019 (Certificate of Eligibility for Exchange Visitor, J-1, Status)



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MEDICAL HISTORY FORM

APPLICANT: Fill this form out then take to physician's office to have completed. This form must be sent in by the doctor's office; otherwise it will not be accepted.

Name: _____ Date of Birth: _____ Social Security: xxx-xx-_____

1. Are you taking any medications? Yes No What Kind? _____
2. Are you allergic to any medication? Yes No What Kind? _____
3. You must submit an original or certified laboratory report which indicates your name and is dated no later than one year prior to South Carolina event or exhibition. The report must indicate that you are HIV, Hepatitis B and C negative. (Wrestlers are excluded from this requirement)
4. Have you ever had any of the following? (Circle answer/answer all questions)

a. Allergies	yes	no	l. Heart Trouble	yes	no
b. Asthma	yes	no	m. Hernia	yes	no
c. Bleeding Tendencies	yes	no	n. Tuberculosis	yes	no
d. Chronic Cough	yes	no	o. Kidney Trouble	yes	no
e. Dizzy or Fainting Spells	yes	no	p. Rheumatic Fever	yes	no
f. Diabetes	yes	no	q. Shortness of Breath	yes	no
g. Eye trouble	yes	no	r. Skin Disease	yes	no
h. Headaches	yes	no	s. Chest Pain	yes	no
i. Seizures	yes	no	t. Psychiatric Problems	yes	no
j. Hepatitis	yes	no	u. Surgery	yes	no
k. Neck Injuries	yes	no	v. Spinal Injuries	yes	no

5. If yes to any of the above, please explain: _____

6. Have you ever been unconscious? Yes No If Yes, when? _____

7. Have you ever sustained any neck, spinal or other injury or have any other information concerning your health, past or present, which is not covered by the previous questions? Yes No If yes, please explain and list the physician diagnosis and treatment. _____

8. Have you had any injuries while training for this bout? Yes No

9. Have you consulted any doctor while training for this bout? Yes No Whom: _____
What treatment have you received? _____

10. Do you have personal medical and hospital insurance coverage? Yes No
Effective Date: _____ Company: _____

Applicant's Signature

Date

**PHYSICAL EXAMINATION
TO BE COMPLETED BY A MD OR DO ONLY**

Doctor's Office should mail or fax both forms to our office. Please see page 1 for address or fax number.

Patient Name: _____ Date of Birth: _____ Social Security: xxx-xx-_____

Pulse: _____ Resp. _____ Height: _____ Weight: _____ BP: _____

Vision (Snellen Chart) **Corrected:** R eye _____ L eye _____ **Uncorrected:** R eye _____ L eye _____

EYES

Ophthalmoscopic exam N X
 Optic Disc N X
 Retina N X
 Central Artery, vein N X

VISUAL FIELDS

PERIORBITAL AREA

Recent Scars N X
 Tenderness N X
 Contusions N X

HENT

Drums N X
 Nasopharynx N X
 Adenopathy N X
 Cranial Nerves N X
 Hearing N X
 Nasal Airway N X

CHEST

Chest X-Ray (if required) N X
 Lungs N X
 Heart N X

ABDOMEN

Liver N X
 Spleen N X
 Hernia N X

NEUROLOGICAL

EKG (if required) N X
 EEG (if required) N X
 MRI (if required) N X
 CAT (if required) N X
 GaitN N X
 Romberg N X

Finger to nose N X
 Knee Jerk N X
 Bicep Jerk N X
 Babiniski N X

ORTHOPEDIC

Flexibility N X
 Other N X

HANDS

Tenderness N X
 Swelling N X
 Deformity N X

Does applicant/licensee appear to be under the influence of any substance to include drugs or alcohol? (Circle one)

YES NO NOT SURE

Conditions (if any) that would prevent this applicant from licensure: _____

 Signature of Examining Physician MD or DO

 License Number

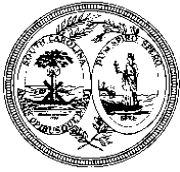
 Date

 Print or Stamp Name of MD or DO

 Phone Number (XXX) XXX-XXXX

 Office Street Address, City, State, Zip

 Fax Number (XXX) XXX-XXXX



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MEDICAL INFORMATION

RELEASE



This form gives the South Carolina Athletic Commission, hereinafter known as SCAC, authorization to distribute medial information to all member commissions affiliated with the Association of Boxing Commissions, hereinafter known as ABC.

I hereby authorize the SCAC to release, disclose and furnish any other commission or program affiliated with the ABC, any and all of my medical records obtained by the SCAC concerning my licensure as a combative sport contestant. This information may consist of, but is not limited to, annual physical examinations, ophthalmologic examinations, neurological examinations, negative test for HIV virus, Hepatitis B virus, and Hepatitis C virus, drug testing, hospital records and any other information regarding conditions related to the propriety of my licensure as a combative sport contestant (including history, findings, diagnosis and prognosis).

I understand, and it is agreed, that the signing of this Medical Information Release is optional and that my declining to sign this document will not result in any adverse action being taken against me by the SCAC or any of the member commission affiliated with the ABC.

I understand, and it is agreed, that the medical records described herein will not be released for any purpose other than the purpose of a member commission affiliated with the ABC to determine my eligibility to participate in a boxing, wrestling or MMA contest.

I understand, and it is agreed, that this authorization shall remain in effect for a period of one year from the date it is signed and is relevant to all medical records described herein whether such records were created prior to or subsequent to the date of the authorization signed.

Signature of Combative Contestant

Boxer Federal ID# or MMA
Contestant's National ID#

Print Name of Combative Contestant

Date Signed

Signature of SCAC Representative

Date Signed