SOUTH DAKOTA DEPARTMENT OF LABOR AND REGULATION

South Dakota Athletic Commission

1351 N. Harrison Ave., Pierre, SD 57501-0340 Ph: 605.224.1721 Fax: 1.888.425.3032

Email: SDAC@midwestsolutionssd.com dlr.sd.gov/bdcomm/athletic

BOXER/KICKBOXER/MIXED MARTIAL ARTIST REGISTRATION APPLICATION

Instructions:

- 1) Open this form in an Adobe reader to complete, print, sign, and mail. Changes made in your internet browser will not save. You can also print the form, fill out legibly and mail.
- 2) A completed Application and \$50 fee must be submitted with application. (Cash or check only)
- 3) Acceptable photo identification must accompany the Application.
- 4) 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.
- 5) Verification of a physical within the previous12 months from a licensed physician must be submitted with application.
- 6) Verification of a dilated eye exam within the previous 12 months from a licensed optometrist or ophthalmologist must be submitted with application.
- 7) Proof the applicant has been tested in the previous 6 months and is negative for HIV, Hepatitis B and Hepatitis C must be submitted with application.
- 8) Verification of a Federal Identification Number.

Legal Name		Professional/Stage Name			
Address		City	State	Zip Code	
Phone	Date of Birth	Social Security Number Fede		eral ID Number	
Height	Weight	Weight/Division			
Eye Color	Hair Color	Distinguishing Marks			
Name of Emergency Contact		Emergency Contact Phone Number			

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.	Do you have any type of medical insurance? If yes, list state(s) and/or jurisdiction(s):

Name of Manager	Manager Name of Trainer Name of Club where you train				
Overall Record as a Professional		Overall Re	Overall Record as an Amateur		
Date of Last Fight	Location of Last Fight	Result of L	ast Fight		
	Medical and Informati	on Release Author	ization		
I authorize the South Dakota At maintained by the South Dakot martial artists, or any medical compartial arts competition overse companies providing insurance South Dakota Athletic Commiss boxing, kickboxing or mixed malagree that a copy of this authoral period of one year from the design of the south of of the s	a Athletic Commission as a corpersonal information acqueen by the South Dakota Ath coverage for a boxing, kickly sion, law enforcement entition that arts competition overselection shall be as valid as a prization shall be as valid as a contract of the sound of the	condition of my reguired as result of colletic Commission to boxing, or mixed mass, or a physician as een by the South Dan original. I furthe	istration as a boxer, ki impeting in a boxing, k o other state licensing artial arts competition ssigned to provide me akota Athletic Commis	ickboxer, or mixed cickboxing or mixed bodies, insurance overseen by the dical services at a ssion.	
Name of Applicant	Signature of	Applicant	 Date		
BY MY SIGNATURE BELOW, I VERIFY, U INFORMATION SUBMITTED IS TRUE AN INACCURACIES OR FAILURES TO MAKE THIS APPLICATION AND MAY BE SUBJE UNDERSTAND THAT I AM RESPONSIBL REGISTRATION FOR AND AM AWARE (REQUIREMENTS. I FURTHER AGREE TO OCCUR AS A RESULT OF PARTICIPATIN	ND CORRECT TO THE BEST OF MY K FULL DISCLOSURE MAY RESULT IN FCT TO CIVIL AND CRIMINAL PROCE E FOR COMPLIANCE WITH SDCL CH DF ALL SAID RESPONSIBILITIES AND D HOLD THE SOUTH DAKOTA ATHL	NOWLEDGE AND THAT THE CANCELLATION OF EDINGS. FURTHERMO HAPTER 42-12 AND ARS OREQUIREMENTS AND	FALSE OR INCORRECT INFO R DENIAL OF A REGISTRATIO RE, I ACKNOWLEDGE THAT D ARTICLE 20:81 IN THE RO AGREE TO ABIDE BY ALL SA	ORMATION, OMMISSIONS ON ISSUED PURSUANT TO I HAVE READ AND DLE(S) I AM SEEKING IID RESPONSIBILITIES AND	
Signature of Applicant			Date		
	For Commis	ssion Use Only			
Fee Physical	Eye Exam	Blood Results	Waiver	Federal ID	

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		
Address			
Signature			
Date			