

SOUTH DAKOTA ATHLETIC COMMISSION

1351 N. Harrison Ave., Pierre, SD 57501
 Tel: 605.224.1721 Fax: 866.425.3032 dlr.sd.gov/athleticcommission

**BOXER | KICKBOXER | MIXED MARTIAL ARTIST
 REGISTRATION APPLICATION**

INSTRUCTIONS

1. A completed Application and \$50 fee must be submitted with application. (Cash or check only)
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 must be submitted with application.
5. Verification of a dilated eye exam within the previous 12 months from a licensed optometrist or ophthalmologist must be submitted with application.
6. 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.
7. Verification of a Federal Identification Number.

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

Please provide answers to the following questions and 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? Yes No
 If yes, please provide the Carrier name and telephone number _____

Name of Manager	Name of Trainer	Name of Club where you train
Overall Professional Record	Overall Amateur Record	
Date of Last Fight	Location of Last Fight	Result of Last Fight

MEDICAL AND INFORMATION RELEASE AUTHORIZATION

I authorize the South Dakota Athletic Commission to release any medical information or other personal information maintained by the South Dakota Athletic Commission as a condition of my registration as a boxer, kickboxer, or mixed martial artists, or any medical or personal information acquired as result of competing in a boxing, kickboxing or mixed martial arts competition overseen by the South Dakota Athletic Commission to other state licensing bodies, insurance companies providing insurance coverage for a boxing, kickboxing, or mixed martial arts competition overseen by the South Dakota Athletic Commission, law enforcement entities, or a physician assigned to provide medical services at a boxing, kickboxing or mixed martial arts competition overseen by the South Dakota Athletic Commission.

I agree that a copy of this authorization shall be as valid as an original. I further agree that this authorization is valid for a period of one year from the date of my signature on this document.

_____/_____/_____
Name of Applicant (Please Print) Applicant's Signature Date

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.

_____/_____/_____
Applicant's Signature Date

<i>Commission Use Only</i>	<i>Fee</i>	_____	<i>Physical</i>	_____
	<i>Eye Exam</i>	_____	<i>Blood Results</i>	_____
	<i>Waiver</i>	_____	<i>Federal ID</i>	_____

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 ____/____/____