



State of Rhode Island
 DEPARTMENT OF BUSINESS REGULATION
 1511 Pontiac Avenue, Bldg. 69-1
 Cranston, Rhode Island 02920

Division of Gaming and
 Athletics Licensing

2020 LICENSE APPLICATION - FEE: \$10.00

BOXING: _____ MMA: _____

PHYSICIANS — (ONLY): _____

(PLEASE PRINT)

Name: First _____ Middle Initial: _____ Last: _____

Address: _____ City: _____ State: _____

COUNTRY: _____ Zip Code: _____ Telephone (including area code): _____

Email Address: _____ @ _____ Driver's Lic #: _____ State: _____

Weight: _____ lbs. Height: _____ Feet: _____ Inches Color Hair: _____ Color Eyes: _____ Race: _____

Social Security Number: _____ • YOUR SSN WILL NOT BE GIVEN OUT — OFFICE USE ONLY

Age: _____ Date of Birth (month-day-year) _____ 1 _____ I _____ Citizen of: _____

Place of Birth: Country: _____ City: _____ State: _____

Have you ever been convicted of a misdemeanor or felony? Yes [] No []
 if "Yes", give details:

Have you ever been disciplined by the Gaming & Athletics Licensing, State of RI or by any other Athletic Commission for any cause whatsoever? Yes [] No []
 If "Yes", give details:

I hereby declare, under penalty of perjury, that I have read the foregoing application for a PHYSICIAN'S license, and all the answers to the questions have been completed by me and that all the answers given are my own, that all the answers are true of my knowledge, that this license expires on December 31 of the year issued (unless otherwise limited by the Commission). Further, I understand and agree that any misrepresentation of a material fact on this application shall constitute grounds for revocation of this license.

 Applicant's Signature Date

PHYSICIAN'S STATEMENT

I hereby attest that my medical malpractice Insurance covers claims arising from performance of the following acts at a Boxing and/or Mixed Martial Arts event held in the State of Rhode Island:

- A. During the event, "observ(ing) the physical condition of the fighters" and determining whether the competitor "is in such condition that to continue might subject him or her to serious injury, "Gaming and Athletics Licensing" Regulation I., Section 18.
- B. Pre-examination, Pursuant to R.I. General Laws Ann. 41-5-11(c), prior to being able to fight, the "physician, licensed under this chapter, shall certify, in writing, that the boxer is physically fit to engage in the proposed contest." "This certification shall be based in part on an examination of the fighter's vision and eye condition" Id.
- C. Post-examination. After the fight, the ring doctor conducts a post-examination and determines whether to recommend the fighter be "discharged" or "referred to P.M.D/Hospital."

APPLICANT/PHYSICIANS SIGNATURE

DATE

APPLICANT/PHYSICIAN MUST SUBMIT A COPY OF THE CERTIFICATE OF INSURANCE FROM HIS/HER MEDICAL MALPRACTICE INSURANCE CARRIER



Tax Payer Status Affidavit / Identity Verification

All persons applying or renewing any license, registration, permit or other authority (hereinafter called "license") to conduct a business or occupation in the state of Rhode Island are required to file all applicable tax returns and pay all taxes owed to the state prior to receiving a license as mandated by state law (RILL 5-76) except as noted below.

In order to verify that the state is not owed taxes, licensees are required to provide their Social Security Number and Federal Tax Identification Number as appropriate. These numbers will be transferred to the Division of Taxation to verify tax status prior to the issuance of a license. This declaration must be made prior to the issuance of a license.

Please complete the below affidavit along with you license application.

<u>Licensee Declaration</u> <u>(Please check below - any that apply)</u>	
<input type="checkbox"/>	I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have paid all taxes due.
<input type="checkbox"/>	I have entered a written installment agreement to pay delinquent taxes that is satisfactory to the Tax Administrator.
<input type="checkbox"/>	I am currently pursuing administrative review of taxes owed to the state.
<input type="checkbox"/>	I am in Federal Bankruptcy. (Case #: _____)
<input type="checkbox"/>	I am in State Receivership. (Case #: _____)
<input type="checkbox"/>	I have been discharged from Bankruptcy. (Case #: _____)

Type of Professional License for which you are applying for.	

Full Name (Please Print or Type)	Social Security Number
_____	_____
Signature	Date
_____	_____

