



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

**Division of Gaming and  
Athletics Licensing**

**2021 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.**

|                                                                                           |                                                                                                                           |
|-------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|
| <b><u>Licensee Declaration</u></b><br><b><u>(Please check below - any that apply)</u></b> |                                                                                                                           |
| <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                                                                                                                      |
| _____                                                                                     | _____                                                                                                                     |

