



# WEST VIRGINIA STATE ATHLETIC COMMISSION

Jim Frio Wheeling, WV P-(304) 233-3168 F-(304) 232-1120	Leon Ramsey Glennville, WV P-(304) 462-5744 F-(304) 462-0300	Paul Thornton Vienna, WV P-(304) 481-0772 F-(304) 232-1120	Tim Peasak, DO Bridgeport, WV P-(304) 842-3330 F-(304) 842-3303	Vacant
--	---	---	--	--------

## Unarmed Combat Sports License Application

MMA Fighter- \$25.00		Pro Boxer- \$25.00		Semi Pro Boxer- 10.00		Amateur- No Fee		Federal ID #:	
Name: (Last, First, Middle)				Ring Name:		Gender			
						M		F	
Address:				City:		State:		Zip:	
SSN:		D.O.B:		Phone:		Email:		Date of Bloodwork:	
HAVE YOU EVER BEEN CONVICTED OF A CRIME OTHER THAN A TRAFFIC OFFENSE? (IF YES, STATE WHEN, WHERE AND WHAT WERE THE CHARGE(S)):									
HAVE YOU EVER BEEN UNDER SUSPENSION? (IF YES, STATE WHEN, WHERE AND TYPE OF SUSPENSION):									
I HEREBY VERIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT. I FURTHER AGREE THAT THE WEST VIRGINIA STATE ATHLETIC COMMISSION MAY USE ANY FILM, PHOTOGRAPH OR OTHER MATERIAL IN WHICH I APPEAR AT THE WEST VIRGINIA STATE ATHLETIC COMMISSION'S SOLE DISCRETION.									
Signature:					Date:				
<b>RELEASE, WAIVER AND HOLD HARMLESS AGREEMENT</b>									
<p>The undersigned, in consideration of the West Virginia State Athletic Commission (the "Commission") approving and allowing my participation in a contest of unarmed combat in the State of West Virginia for myself, my heirs, executors, administrators, successors, and assigns, do hereby release, remise and forever discharge the Commission and each of their members, agents, and/or employees in their individual and representative capacities, from any and all manner of actions, causes of action, suits, debts, judgments, executions, claims and demands whatsoever, including negligence, known and unknown, in law or equity, that I ever had, now have, may have or claim to have against the Commission, arising out of or by reason of my participation in any contest of unarmed combat held in the State of West Virginia, or any other matter relating thereto.</p> <p>I understand that by participating in a contest of unarmed combat that I am engaging in an abnormally dangerous activity. I further understand and acknowledge that this participation subjects me to a risk of severe injury (both physical and mental) or death. I, with full knowledge of this risk, nonetheless, agree to enter into this agreement and assume and accept such risks of injury and/or death and hereby waive and/or release any claim that I, or my heirs, may have against the Commission and/or their agents as the result of any injury and/or death I may suffer as a result of my participation in any contest or exhibition of unarmed combat in the State of West Virginia.</p> <p>I also hereby hold harmless the Commission and each of its members, agents, independent contractors and employees in their individual and representative capacities against any and all claims, suits and actions including negligence, brought against the Commission by reason of my participation in any contest of unarmed combat held in the State of West Virginia and all other matter relating thereto and for any and all expenses, damages and costs and attorney fees, which may be sustained by the Commission as a result of said claims, suits and/or actions.</p>									
Dated this _____ day of _____, 20_____.									
_____ Participant Signature					_____ 1 <sup>st</sup> Witness Signature				



# WEST VIRGINIA STATE ATHLETIC COMMISSION

## HIPAA Compliant Authorization Form Pursuant to 45CFR164.508

Name of specific identification of the person(s) or class of persons authorized to make the requested disclosure:

**WEST VIRGINIA STATE ATHLETIC COMMISSION AND ANY OF ITS COMMISSIONERS and/or Representatives**

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

I authorize the disclosure of all protected information and I expressly request that all covered entities under HIPAA identified above may disclose full and complete protected information within their possession, including permitting them to release and/or discuss the following:

All information of a medical nature which has been supplied to the Commission and as well to permit them to discuss with any and all person all facts and information provided to the Commission and forming a part of the licensing procedures and/or related to my ability to request to engage in a professional unarmed combat match in the State of West Virginia, including but not limited to, the following:

All medical records including inpatient, outpatient and emergency room treatment, all clinical charts, reports, documents, correspondence, test results, statements, questionnaires/histories, office and doctors' handwritten notes and records received by other physicians and verbal information received from any medical personnel, including any physicians;

All laboratory, histology, cytology, pathology, radiology, CT scan, MRI, echocardiogram and cardiac catheterization reports;

All radiology films, mammograms, myelograms, CT scans, photographs, bone scans, pathology/cytology/histology/autopsy/immunohistochemistry specimens, cardiac catheterization videos/CDS films/reels, and echocardiogram videos;

All pharmacy/prescription records, including NDC numbers and drug information handouts/monographs;

All billing records including all statements, itemized bills and insurance records; and

All licensing information required by the Commission that regulates or oversees unarmed combat sports.

\*Information about alcohol/substance abuse and HIV/AIDS may be disclosed as follows (INITIAL all that apply):

\_\_\_\_\_ Yes, disclose HIV/AIDS information.

\_\_\_\_\_ No, do not disclose HIV/AIDS information.

\_\_\_\_\_ Yes, disclose Alcohol/Substance Abuse information.

\_\_\_\_\_ No, do not disclose Alcohol/Substance Abuse information.

I authorize you to release the protected health information to any and all persons and/or entities, including news media and state athletic commissions upon request.

I acknowledge the right to revoke this authorization by writing to the West Virginia State Athletic Commission. However, I understand that any actions already taken in reliance on this authorization cannot be reversed and any revocation will not affect those actions.

I acknowledge the potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and no longer be protected under 45CFR164.508.

I understand that the covered entity to which this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign an authorization.

Any facsimile, copy or photocopy of this authorization shall authorize you to release the records herein.

This authorization expires two (2) years from the date below.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_