NOTICE OF MEDICAL SUSPENSION FOR COMBATIVE SPORTS

First Name: _____ Last Name: _____ Date of Suspension: _____

☐ No Medical Suspension (Mandatory 7 Day rest)
☐ Medical Suspension - In accordance with the USA Muaythai Combative Sports Director statutes/regulations you are hereby suspended from sparring and competing in any combat sport for medical reasons as of the date indicated above.

Suspension is effective for:

☐ _____ Days (no medical clearance required)
☐ Indefinite Suspension with _____ Days - Minimum medical suspension

Injuries Sustained/Reason for Suspension:

☐ KO ☐ TKO ☐ With Head Trauma (minimum 30-day medical suspension required)
☐ Facial injury ☐ Excessive blows ☐ Laceration(s) ☐ Orthopedic injury ☐ Eye injury ☐ Extremity injury
☐ Other: _____

If medically suspended: Participant has been suspended for the medical reasons indicated above and must refrain from training/sparring with any physical contact, competing in any combative sports, or doing any activity in which Participant's head would be shaken or hit for the duration of the suspension. The suspension may be extended if further stress to any injured area is sustained. This suspension should be reported to your personal physician. Participant may request to have this medical suspension reviewed by the Director for clearance at a later date, upon the submission of a physician's report, evaluation and documentation demonstrating to the satisfaction of the Director that the medical suspension imposed by this Notice is no longer warranted. Participant may be required to submit documents or results pertaining to your medical clearance in writing to the Director for review before being permitted to compete again.

Medical Requirements for Suspension Clearance:

Upon the recommendation of the attending physician and in accordance with applicable laws/statutes you must satisfactorily pass any medical tests and/or evaluations recommended. The following shall be required for clearance:

☐ CT Scan ☐ X-Ray ☐ MRI ☐ Evaluation of Hematuria ☐ Other:_____
Body Part(s): _____

Examination/follow up and clearance by:

☐ Ophthalmologist ☐ Neurologist ☐ Orthopedic doctor ☐ Primary care doctor ☐ Other: _____
☐ Post-bout urine test required (Determined by CCSC) ☐ Post-bout urine completed (Cannot be discharged until completed)

FINAL DISPOSITION TIME: TIME: _____

☐ Discharge home with instructions ☐ Refused medical advice/treatment; Left without being examined
☐ Transfer to ER via ambulance (emergent). Hospital Name: _____
☐ Refer for non-emergent care (no ambulance required) to ER, urgent care center, or PMD within _____ hours
☐ Other: _____
Comments: _____

Participant Certification

By signing the form below, I certify that the Participant has been examined by the physician as indicated above following the Participant's participation in a combative sports contest. The physician advised Participant of the nature of any injuries sustained, as noted above, and recommended treatment, medical follow-up and/or clearance. Participant might be at increased risk of brain injury following a combative sports competition and should seek immediate medical attention if any of the following symptoms develop:

HEADACHE	SEIZURES OR UNCONTROLLABLE SHAKING	LOSS OF CONSCIOUSNESS OR PASSING OUT
NAUSEA OR VOMITING	CONFUSION OR MEMORY LOSS	WEAKNESS IN AN ARM OR LEG
BLURRED OR DOUBLE VISION	NUMBNESS OR TINGLING IN AN ARM OR LEG	DECREASED COORDINATION
BALANCE PROBLEMS	DIFFICULTY CONCENTRATING	LETHARGY OR DROWSINESS
DIZZINESS	DIFFICULTY WALKING	

Participant: _____ Signature: _____ Date: _____

Physician Certification

I have examined the above-named Participant and have explained to Participant the nature of any injuries sustained as well as recommended treatments, have advised the Participant/Participant's Manager regarding all fields noted above and have prescribed a period of medical suspension as indicated on this report.

Physician, MD/DO: _____ Signature: _____ Date: _____