

ISCF FIGHTERS MEDICAL ATTENTION FORM

This form is for the Injured Fighter to Present for Medical Attention at a Hospital or Doctors Office

1. FIGHTER'S NAME: _____
2. PROMOTER'S NAME: : _____
3. PROMOTER'S PHONE CONTACT INFO: _____
4. EVENT DATE: ____/____ 20____
5. EVENT VENUE NAME: _____
6. EVENT CITY: _____ STATE/PROV: _____ COUNTRY: _____
7. PHYSICIANS EXPLANATION OF MEDICAL ISSUE OR NEEDS OF ATTENTION:

8. REQUIRE OR SUGGESTED MEDICAL TESTS: _____
9. PROMOTERS INSURANCE COMPANY _____
10. INSURANCE COMPANY CONTACT INFO: _____
11. INSURANCE POLICY NUMBER _____
12. Executed at _____ AM/PM, on this _____ day of _____, in the year 20____
13. FIGHTERS PRINTED NAME: _____
14. FIGHTERS SIGNATURE: _____ DATE: ____/____ 20____
15. PROMOTERS PRINTED NAME: _____
16. PROMOTERS SIGNATURE: _____ DATE: ____/____ 20____
17. ISCF REPRESENTATIVES PRINTED NAME: _____
18. ISCF REPRESENTATIVES SIGNATURE: _____ DATE: ____/____ 20____
19. EVENT MEDICAL DOCTORS PRINTED NAME: _____
20. EVENT MEDICAL DOCTORS SIGNATURE: _____ DATE: ____/____ 20____



ISCF - International Sport Combat Federation
P. O. Box 1205, Newcastle, CA, 95658, 9250 Cypress Street, Newcastle, CA, 95658, USA
(916) 663-2467, Fax: (916) 663-4510 or info@iscfmma.com - www.ISCFMMA.com