



Association of
Boxing Commissions
and Combative Sports

PRE-FIGHT BRAIN MRI INTERPRETATION FORM

NOTE: Only a licensed radiologist, neurologist or neurosurgeon may complete this form

NAME: _____ EXAM DATE: _____

ADDRESS: _____

CITY: _____ STATE: _____ COUNTRY: _____

PHONE: _____ DATE OF BIRTH: _____

TYPE OF MRI CONDUCTED? _____

*IS THIS MRI EXAMINATION WITHIN NORMAL LIMITS? YES NO

IS FURTHER REFERRAL OR EXAMINATION NEEDED? YES NO

IF SO, FURTHER RECOMMENDATIONS INCLUDE:

BASED ON THIS MRI, THE FIGHTER:

IS IS NOT MEDICALLY CLEARED TO PARTICIPATE

Physicians Name: _____

Physician Signature: _____

Address: _____ City: _____

State: _____ Country: _____ Zip: _____

Phone: _____ Fax: _____

***PLEASE INCLUDE A COPY OF THE ACTUAL MRI EXAMINATION REPORT WITH THIS FORM**