ISCF FIGHTERS MEDICAL ATTENTION FORM

This form is for an injured Fighter to present for Medical Attention at a Hospital or Doctors Office chosen.

- **FIGHTER'S NAME: _____ AGE: _____**
- **PROMOTER'S NAME: _____**
- **PROMOTER CONTACT INFO: _____**
- **EVENT DATE: ___/___ EVENT YEAR: 200____**
- **VENUE NAME: _____**
- **EVENT CITY: _____ STATE:_____**
- **PHYSICIANS EXPLANATION OF MEDICAL ISSUE OR NEEDS OF ATTENTION:**
  _____
  _____
- **REQUIRE OR SUGGESTED MEDICAL TESTS:**
  _____
- **PROMOTERS INSURANCE COMPANY**
  _____
- **FIGHTER'S CONTACT INFO: _____**
- **INSURANCE POLICY NUMBER: _____**
- **INSURANCE COMPANY NAME: _____**

Executed at _____AM/PM, on this _____day of _____, in the year 200___

FIGHTERS SIGNATURE: _____ DATE: _____/_____ 200___

PROMOTERS SIGNATURE: _____ DATE: _____/_____ 200___

ISCF REPRESENTATIVES PRINTED NAME: _____

ISCF REPRESENTATIVES SIGNATURE: _____ DATE: _____/_____ 200___

EVENT MEDICAL DOCTORS PRINTED NAME: _____

EVENT MEDICAL DOCTORS SIGNATURE: _____ DATE: _____/_____ 200___

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