State of New Jersey

Jon S. Corzine
Governor

OFFICE OF THE ATTORNEY GENERAL
DEPARTMENT OF LAW AND PUBLIC SAFETY
STATE ATHLETIC CONTROL BOARD
P.O. BOX 180
TRENTON, NJ 08625-0180

Anne Milgram
Attorney General

Tony Orlando
Chairman

Steven Katz
Dennis McDonough
Member

SYLVESTER CUYLER
Acting Commissioner

TO: PROFESSIONAL BOXING/KICKBOXING/MIXED MARTIAL ARTS TIMEKEEPERS

FROM: Larry Hazzard, Sr.
Commissioner

SUBJECT: New Jersey Professional Boxing/Kickboxing/Mixed Martial Arts Timekeeper License Application
RENEWAL: July 1, 2007 - June 30, 2008

Enclosed are the annual requirements for license as a Professional Boxing /Kickboxing/Mixed Martial Arts Timekeeper in the State of New Jersey.

You must submit the following to this office:

1. Completed License Application Form;

2. Completed Physical Examination Form

3. Completed Official's Disclosure Form

4. Original EKG report, interpreted by a physician;

5. Original EYE examination by an optometrist; and

6. Check or money order in the amount of $25.00 payable to the State Athletic Control Board

NOTE: Proof of medical testing must be provided through **ORIGINAL DOCUMENTS** indicating date of test, location of test and identification of the doctor. The date, location and name of doctor who reviews the medical test results must also be provided. Medical tests and examinations must be dated within **180** days of application.

To reduce the costs for individual tests, the Board has obtained an agreement from Millville Hospital, near Atlantic City, to provide medical testing at specific rates. For further information, contact Millville Hospital at (856)451-8700, ext. 54835 and ask for Joan Pierce of South Jersey Medical Systems.

AN INCOMPLETE APPLICATION WILL BE RETURNED TO YOU, DELAYING ISSUE OF YOUR LICENSE AND FUTURE SHOW ASSIGNMENTS.

LICENSEES ARE REMINDED: You are subject to the requirements of State Athletic Control Board Rules, provided by Chapter 46 of New Jersey's Administrative Code.

If there are any questions regarding your application, please contact the office at 609.292.0317.

LH:tg
Enclosures
REV: 05.2005

PLEASE MAKE CHECK OR MONEY ORDER PAYABLE TO N.J.S.A.C.B. *
*****NO CASH!!*****

NEW JERSEY STATE ATHLETIC CONTROL BOARD
LICENSE APPLICATION

P. O. Box 180
Trenton, New Jersey 08625-0180
Telephone: (609)292-0317 Fax: (609)292-3756

Check (✓) or Circle Type/s of License

CONTESTANT	MANAGER	SECOND	
❒ Boxer $5	❒ Boxing $25	❒ Boxing $25	❒ Announcer $25
❒ Kickboxer $5	❒ Kickboxing $25	❒ Kickboxing $25	❒ Timekeeper $25
❒ Mixed Martial Artist $5	❒ Mixed Martial Arts $25	❒ Mixed Martial Arts $25	❒ Other $____
			_____

REFEREE	JUDGE	PROMOTER	MATCHMAKER
❒ Boxing $75	❒ Boxing $75	❒ Boxing $300	❒ Boxing $100
❒ Kickboxing $75	❒ Kickboxing $75	❒ Kickboxing $300	❒ Kickboxing $100
❒ Mixed Martial Arts $75	❒ Mixed Martial Arts $75	❒ Mixed Martial Arts $300	❒ Mixed Martial Arts $100

SECTION I (All Applicants) - Please Print

NAME: AKA or ALIAS (Other Names Used):

ADDRESS: CITY: STATE: ZIP: COUNTRY:

MAILING ADDRESS **(complete if different from above)** CITY: STATE: ZIP: COUNTRY:

TELEPHONE (Residence): ( ) TELEPHONE (Business): ( ) FAX# ( ) E-MAIL ADDRESS:

DATE OF BIRTH: SOCIAL SECURITY#: HEIGHT: WEIGHT:

SEX: ❒ MALE ❒ FEMALE CITIZENSHIP: PLACE OF BIRTH:

Have you ever been convicted of a crime? If yes, explain: ❒ YES ❒ NO

Are you presently on any suspension list? If yes, explain: ❒ YES ❒ NO

Have you ever been disqualified in any contest or disciplined for your actions during a contest? ❒ YES ❒ NO
If yes, explain:

Has any license you've held been revoked? If yes, please explain: ❒ YES ❒ NO

List all other Athletic Commissions in which you are licensed:

SECTION II (Boxer's, Kickboxer's & Mixed Martial Artist Only) - Please Print

Have you ever been hospitalized due to an injury suffered in any contest? If yes, explain: ❒ YES ❒ NO

Do you have any current medical conditions? If yes, please explain: ❒ YES ❒ NO

Do you have a manager? If yes, provide name, address & telephone number: ❒ YES ❒ NO

Name: **Address:** **Telephone No: (_____)**

Have you had amateur experience**?** If yes, complete the following questions: ❒ YES ❒ NO

Amateur Record: _____ **Number of Fights:** _____

Submission Grappling Record:_____

Name of Gym or Club where you trained**:** _____

Name and Telephone Number of Trainer or Manager:

Name:_____ **Telephone Number:** __(_____)_____

SECTION III (Manager's & Second's Only) Please Print

List names of boxers which you currently manage/second:

Do you know of any medical conditions which your boxers currently have?: If yes, please explain ❒ YES ❒ NO

I THE UNDERSIGNED HEREBY DECLARE THAT I HAVE READ THIS APPLICATION AND THAT ALL THE ANSWERS TO THE QUESTIONS ARE TRUE AND COMPLETE. I UNDERSTAND THAT ANY MISREPRESENTATION OR FAILURE TO ANSWER SHALL CONSTITUTE GROUNDS FOR LICENSE REVOCATION AND OR OTHER APPLICABLE LEGAL PENALTIES.

I ALSO UNDERSTAND THAT BY SIGNING THIS APPLICATION THAT I AM AUTHORIZING THE STATE ATHLETIC CONTROL BOARD TO CONDUCT A FULL INVESTIGATION INTO MY BACKGROUND AND ACTIVITIES. I UNDERSTAND THAT THE OFFICE OF THE ATTORNEY GENERAL AND THE NEW JERSEY STATE POLICE MAY PARTICIPATE IN THIS BACKGROUND INVESTIGATION.

TO ALL COURTS, PROBATION DEPARTMENTS, SELECTIVE BOARDS, EMPLOYERS, EDUCATIONAL INSTITUTIONS, FINANCIAL INSTITUTIONS AND ALL GOVERNMENT AGENCIES, FEDERAL, STATE AND LOCAL, WITHOUT EXCEPTION, BOTH FOREIGN AND DOMESTIC. I HAVE APPLIED FOR A LICENSE WITH THE STATE ATHLETIC CONTROL BOARD AND FOR THE PURPOSE OF THIS APPLICATION, YOU ARE HEREBY AUTHORIZED TO RELEASE ANY AND ALL INFORMATION PERTAINING TO ME, DOCUMENTARY OR OTHERWISE, AS REQUESTED BY ANY APPROPRIATE EMPLOYEE, AGENT OR REPRESENTATIVE OF THE STATE ATHLETIC CONTROL BOARD, THE OFFICE OF THE ATTORNEY GENERAL OR THE NEW JERSEY STATE POLICE.

I THE UNDERSIGNED STATE THAT A PHOTOSTATIC COPY OF THIS AUTHORIZATION WILL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

FURTHER, I AM AWARE AND AGREE THAT MY SIGNATURE CONSTITUTES A WAIVER OF LIABILITY AS TO THE STATE OF NEW JERSEY AND ITS INSTRUMENTALITIES AND AGENTS FOR ANY DAMAGES RESULTING IN DISCLOSURE OR PUBLICATION IN ANY MANNER, OTHER THAN A WILLFULLY UNLAWFUL DISCLOSURE OR PUBLICATION, OF ANY MATERIAL OR INFORMATION ACQUIRED DURING THE LICENSURE CONSIDERATION PROCESS OR DURING ANY INVESTIGATIONS, INQUIRY OR HEARING.

I HEREBY AUTHORIZE THE RELEASE OF ANY CRIMINAL HISTORY RECORD INFORMATION TO THIS AGENCY ONLY FOR THE EXPRESS PURPOSE OF PROCESSING MY APPLICATION FOR A LICENSE. THE AUTHORITY TO REQUEST CRIMINAL INFORMATION IS SET FOR IN *N.J.S.A. 5:2A-15.*

I UNDERSTAND THAT THE DISCLOSURE OF MY SOCIAL SECURITY NUMBER ON THIS APPLICATION IS VOLUNTARY AND THAT IT WILL ONLY BE USED FOR PURPOSES OF PROCESSING MY APPLICATION.

DATE:_____ SIGNATURE:_____

REV: 01.12.06

State of New Jersey
Department of Law & Public Safety
State Atlethic Control Board

CHILD SUPPORT QUESTIONS

Please certify, under penalty of perjury, the following:

	YES	NO
1. Do you currently have a child-support obilgation?	☐	☐
a. If "YES", are you in arrears in payment of said obilgation?	☐	☐
b. If "YES", does the arrearage match or exceed the total amount payable for the past six months?	☐	☐
2. Have you failed to provide any court-ordered health insurance coverage during the past six months?	☐	☐
3. Have you failed to respond to a subpoena relating to either a paternity or child-support proceeding?	☐	☐
4. Are you the subject of a child-support-related arrest warrant?	☐	☐

In accordance with N.J.S.A. 2A:17-56.44d, an answer of "YES" to any of the questions numbered 1a through 4 will result in a denial of licensure. Furthermore, any false cerification of the above may subject you to a penalty, including, but not limited to, immediate revocation or suspension of licensure.

Applicant's name (please print)	Applicant's signature	Date

***Social Security Number:** _____ - _____ - _____

You **must** disclose your Social Security Number for the reasons stated below. Failure to do so may result in a denial of licensure or license renewal.

Please return this form to:

State of New Jersey
State Athletic Control Board
25 Market Street
P.O. Box 180
Trenton, NJ 08625-0180

PHYSICAL EXAMINATION - OFFICIALS

Blood Presure no higher than 90 m/m Hg. ❒
Temperature below 100˚F or 37˚C ❒
Fundi - no retinopathies or cataracts ❒
No hernias nor viscero-megaly ❒
Normal Rhomberg and finger to nose test ❒
No suppurative lesions on skin ❒
No indications of active renal disease ❒

EXAMINATION

Ears
Otoscopy (Normal-Abnormal) Describe:
_____
_____

Mouth pharynx (teeth) (Normal-Abnormal) Describe:
_____
_____

Adenopathys No Yes (Location)
_____
_____

Lungs (Normal-Abnormal) Describe:
_____
_____

Heart (Normal-Abnormal) Describe:
_____
_____

Abdominal palpation (Normal-Abnormal) Describe:
_____
_____

Hernias (No-Yes) Describe:
_____
_____

Testis (Normal-Abnormal) Describe:
_____
_____

Tendon Reflexes	Normal	Abnormal
Knee jerk	Rt.____ Lft.____	Rt.____ Lft.____
Babinski	Rt.____ Lft.____	Rt.____ Lft. ____

Rhomberg:_____
Finger to nose:_____

Upper Extremities (Normal-Abnormal) Describe:

Hands:_____
Wrist:_____
Elbows:_____
Shoulder Girdle:_____
Lower Extremities:_____

Skin (Open or Supurative lesions) Yes No
_____
_____
_____

Urinalysis:
Albumin:_____
Glucose:_____
Micro:_____
Hematuria:_____

Blood-test:

Hemaglobin and Hematocrit_____

Electrocardiogram _____ Date:_____

Examiners comments:
_____
_____

Physician
Name (printed):
_____

Address:_____
_____

Phone:_____

Name:_____

Home Address:
_____
_____

Phone:_____

Birth Date:_____

Exam Date:_____

IMPORTANT

BLOOD TYPE: _____

ALLERGIES:
_____

==========

Pulse:_____ Blood Pressure:_____

Temperature:_____ Weight:_____

OPTOMETRIST EXAM **DATE:_____**

EYES	RIGHT	LEFT
Distant Vision	20/	20/
Light Reflex	Normal Abnormal	Normal Abnormal
Accommodation Reflex	Normal Abnormal	Normal Abnormal

Comments:
_____
_____

Physcian:
Name (printed):_____

Address:_____

Phone: _____

OFFICIAL'S DISCLOSURE FORM

1. What is your profession or occupation?_____

2. Who is your current employer? _____

   If not currently employed, please list your most recent employer?

   _____

3. What is your business address and telephone number?

   _____

   _____

4. What is your home address and telephone number?

   _____

   _____

-over-

5. Are you licensed as a professional boxing official in any other jurisdiction?

☐ YES ☐ NO

(If yes, please explain)_____

_____

6. Has any boxing license you have ever held been suspended or revoked?

☐ YES ☐ NO

(If yes, please explain)_____

_____

7. Have you ever been denied a professional boxing official's license?

☐ YES ☐ NO

(If yes, please explain)_____

_____

8. Do you have any direct or indirect financial interest in, or direct or indirect financial dealings with, any professional boxer, manager, second, trainer, promoter, matchmaker, sanctioning organization, or boxing media personality?

☐ YES ☐ NO

(If yes, please explain)_____

_____

-more-

9. Do you have any direct or indirect financial interest with any company, partnership, or individual who is involved in the sport of boxing?

☐ YES ☐ NO

(If yes, please explain)_____

_____

10. Please list all organizations, associations, groups, or charitable foundations related to boxing that you are currently a member of, or have been in, the last 12 months.

_____

_____

_____

11. Are you, your spouse, or any of your parents, brothers, sisters, cousins, nieces, nephews, aunts, uncles, or grandchildren related to any professional boxer, manager, second, trainer, promoter, matchmaker, sanctioning organization official, or boxing media personality?

☐ YES ☐ NO

(If yes, please explain)_____

_____

12. Are you, your spouse, or any of your parents, brothers, sisters, cousins, nieces, nephews, aunts, uncles, or grandchildren a personal friend of any professional boxer, manager, second, trainer, promoter, matchmaker, sanctioning organization official, or boxing media personality?

☐ YES ☐ NO

(If yes, please explain)_____

_____

-over-

13. Have you been offered or received any gifts, complementaries, or other things of value from any professional boxer, manager, second, trainer, promoter, matchmaker, sanctioning organization, or boxing media personality?

☐ YES ☐ NO

(If yes, please explain)_____

_____

14. Have you been arrested by any law enforcement agency in the past twelve months?

☐ YES ☐ NO

(If yes, please explain)_____

_____

I CERTIFY THAT THE INFORMATION WHICH I HAVE PROVIDED ABOVE IS TRUE AND ACCURATE AND I UNDERSTAND THAT IT IS MY OBLIGATION TO NOTIFY THE SACB, IN WRITING, IMMEDIATELY, IF ANY OF MY RESPONSES TO THE ABOVE QUESTIONS CHANGE. I FURTHER UNDERSTAND THAT ANY OMISSIONS, INACCURACIES OR THE FAILURE TO MAKE FULL DISCLOSURES MAY BE DEEMED SUFFICIENT REASON TO DENY A LICENSE OR TO WITHHOLD RENEWAL OF, OR SUSPEND OR REVOKE, A LICENSE IF ISSUED BY THE BOARD. THE UNDERSIGNED APPLICANT UNDERSTANDS THE BOARD OR COMMISSIONER MAY MAKE SUCH INQUIRY AND INVESTIGATION CONCERNING THE APPLICANT'S RECORD OR BACKGROUND AS THE BOARD OR COMMISSIONER, IN THEIR JUDGEMENT, DEEMS PROPER, AND SAID APPLICANT FURTHER AGREES TO FURNISH ANY ADDITIONAL INFORMATION REQUESTED BY THE BOARD OR COMMISSIONER.

Date: _____ Print Name: _____

Signature: _____

This form must be faxed back to the SACB at (609) 292-3756 at least 10 days before the scheduled event in order to be considered for a position at that event. If you have any questions, please contact the SACB at (609) 292-0317.

STATE OF NEW JERSEY
W-9/QUESTIONNAIRE

THE STATE OF NEW JERSEY REQUIRES COMPLETION OF THE W-9/VENDOR QUESTIONNAIRE TO VERIFY/ESTABLISH YOUR NAME, ADDRESS, AND TAXPAYER ID ON STATE RECORDS. PLEASE REVIEW THE INFORMATION BELOW, CORRECT ERRORS, AND ANSWER THE QUESTIONS PER SPECIFIC INSTRUCTIONS. RETURN THE COMPLETED FORM TO THE STATE IN THE ENVELOPE PROVIDED AS SOON AS POSSIBLE.

IMPORTANT: YOU WILL NOT BE PAID BY THE STATE OF NEW JERSEY UNTIL THIS FORM IS COMPLETED, SIGNED, AND RETURNED TO THE STATE OF N.J. FOR ADDITIONAL INFORMATION CALL (609) 292-8124.

PART I. D NAME/ADDRESS (REMIT TO:)	REQUEST FOR TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION Enter your taxpayer identification number and indicate whether it is a social security or employer identification number by marking the appropriate box.	Return completed form to: OMB VENDOR CONTROL PO BOX 221 TRENTON, N.J. 08625 FAX 609-292-4882

Make any corrections to the pre-printed data in the space provided below. Please type or print clearly.

4. Taxpayer Identification Number (TIN) (Enter your correct TIN below ONLY if it differs from the # printed in the box.)

MARK THE APPROPRIATE BOX:
- ☐ SOCIAL SECURITY NUMBER
- ☐ EMPLOYER IDENTIFICATION NUMBER

5. For Payees Exempt From Backup Withholding (Contact the IRS for instructions)

Requester's name and address (optional)

6. Certification: Under penalties of perjury, I certify that:

(1) The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me) AND

(2) I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding.

Certification Instructions: You must cross out item (2) above if you have been notified by the IRS that you are currently subject to backup withholding because of underreported interest or dividends on your tax return. For real estate transactions, item (2) does not apply. For mortgage interest paid, the acquisition or abandonment of secured property, cancellation of debt, contributions to an IRA, and generally payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN.

Please Sign Here — Signature > — Date >

PART II. VENDOR DATA — STATE OF NEW JERSEY VENDOR INFORMATION QUESTIONNAIRE

1. Enter the code from the list below that best describes your business function:

☐☐

VENDORS
- HC = HEALTH CARE SERVICE (NON-STATE AGENCIES)
- VG = VENDORS WHO SELL OR MANUFACTURE GOODS
- VS = VENDORS WHO RENDER A SERVICE OR VENDORS WHO RECEIVE RENT PAYMENTS

GOVERNMENTAL ENTITIES
- AC = AUTHORITY/COMMISSION
- CF = CONFIDENTIAL FUND
- CM = COUNTY/MUNICIPAL GOVT.
- CU = STATE COLLEGE/UNIVERSITY
- EP = NJ STATE EMPLOYEE
- FA = FEDERAL AGENCY
- FD = FIRE DISTRICT
- PC = PETTY CASH
- SA = STATE AGENCY
- SD = SCHOOL DISTRICT
- WB = WELFARE BOARD

MISCELLANEOUS VENDORS

OT = OTHER MISCELLANEOUS VENDORS (Please Specify) _____

2. Enter Primary Contact Information Below.

PHONE: (___) _____ - _____ NAME: _____ TITLE: _____

IF YOU ARE A NJ STATE EMPLOYEE, NJ MANAGER OF A CONFIDENTIAL FUND OR A PETTY CASH FUND, DO NOT ANSWER THE BALANCE OF THE QUESTIONNAIRE.

3. What is the principal activity of your organization?

☐ M = MANUFACTURING H = HEALTH RELATED SERVICE
S = SERVICE G = GOVERNMENT O = OTHER (Please Specify) _____

4. Enter the code from the list below that best describes your organization:

☐ C = CORPORATION I = INDIVIDUAL P PARTNERSHIP
A = ASSOCIATION J = JOINT O OTHER (Please Specify) _____

5. Enter your 4 digit County/Municipality Code for NJ Addresses ONLY (See reverse side for appropriate code.)

☐☐☐☐

IMPORTANT: ANSWER ALL QUESTIONS (Please Print or Type Clearly)