

Kentucky Boxing and Wrestling Commission

656 Chamberlin Avenue, Suite B
Frankfort, Kentucky 40601



Email: KBWC@ky.gov
Phone: (502) 564-0085
Fax: (502) 696-3938

MEDICAL PROVIDER APPLICATION

Instructions: Please complete both pages of this application. Applications shall be printed legibly and in ink. Incomplete applications are subject to rejection and will cause delay in issuance of a license.

Applications for licensure as a physician or healthcare professional are required annually. The license fee for a physician or healthcare professional is twenty-five (25) dollars. Licenses are valid from January 1st – December 31st. Make payment in the form of a check or money order, made payable to the *Kentucky State Treasurer*.

I am applying for licensure as a: (circle one)

Physician
\$25

Healthcare Professional
\$25

Name: _____ Date of Birth: _____

Address: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Fax: _____ E-mail: _____

Healthcare Occupation: _____ Employer: _____

Employer Address: _____

Professional License #: _____ Expiration Date: _____

How long have you licensed in this profession? _____

Emergency Contact: _____ Relation: _____ Phone: _____

(OVER)

Describe your experience that would support your being granted a license.

(Continue on a separate sheet if needed): _____

Have you ever held a license from the commission? **YES** **NO**

If yes, what sport(s): _____ License number(s): _____

Have you ever been licensed as a healthcare professional by another states boxing and wrestling governing body?

YES **NO** If yes, what state(s): _____ Sport(s): _____

License Number(s): _____

Have you ever been convicted of a crime? **YES** **NO**

If yes, please provide details: **FELONY** **MISDEMEANOR**

Date: _____

Offense: _____ Court: _____

Disposition: (Use another sheet of paper if necessary) _____

I certify under penalty of perjury that all of the information submitted in this application is true and complete. I am aware that submitting false information or omitting pertinent or material information in connection with this application is grounds for license revocation or denial of the license and may subject me to civil or criminal penalties. I acknowledge that I understand and will comply with the Kentucky Boxing and Wrestling Commission laws and regulations to which I am applying for licensure.

Signature of Applicant

Date

PLEASE MAIL OR HAND DELIVER THE COMPLETED APPLICATION AND \$25 FEE TO THE COMMISSION.