NZMMAF
NEW ZEALAND MIXED MARTIAL ARTS FEDERATION

NOTICE OF MEDICAL SUSPENSION

ATHLETE'S LEGAL NAME: _____

In accordance with **NZMMAF's medical and safety standards**, your eligibility to participate in NZMMAF-sanctioned events has been **suspended for medical reasons,** effective as of the date below.

1. SUSPENSION REASON

☐ KO

☐ TKO

☐ Excessive blows to head

☐ Laceration(s)

☐ Orthopedic injury

☐ Eye injury

☐ Other:_____

2. SUSPENSION DURATION

Number of days immediately following _____/_____/_____ (date of contest):

3. SUSPENSION ACTIVITY RESTRICTIONS

No Sparring/Contact	**&**	**No Competition**	**Tick applicable suspension period**
30 days	&	45 days	
45 days	&	60 days	
60 days	&	90 days	
90 days	&	120 days	
Indefinite pending medical clearance			

Other:

4. REQUIRED MEDICAL TESTING AND EVALUATION

Upon the recommendation of medical personnel and in line with NZMMAF's medical and safety standards, you are required to complete any medical tests or evaluations advised by the examining professional.

You may be asked to provide written confirmation of medical clearance, including test results, before being permitted to resume participation in any NZMMAF-sanctioned events.

5. ATHLETE AND COACH/MANAGER ACKNOWLEDGEMENT

I certify that I have been examined by the designated medical personnel following my participation in an NZMMAF-sanctioned MMA contest. The event medical personnel have informed me of the nature of any injuries sustained and the recommended treatment.

I acknowledge that I have been suspended from competition and training due to the medical reasons listed above. I agree to **refrain from all contact training, sparring, competition** in any combative sports, or any activity that may risk further injury - particularly any activity that may involve **head trauma or physical stress** to the affected area - **for the duration of the suspension**.

I understand that the suspension may be extended if further stress or injury occurs.

I agree to seek further medical care and report this suspension to my doctor if I experience **persistent headaches, seizures, or any other concerning symptoms**.

Athlete Signature	
Date (dd/mm/yy)	

Coach/Manager Signature	
Date (dd/mm/yy)	

6. MEDICAL PERSONNEL CERTIFICATION

I certify that I have examined the above-named athlete, have explained the nature of their injuries and recommended treatment, and have prescribed a period of medical suspension as outlined in this notice.

Medical Personnel Signature	
Date (dd/mm/yy)	

This suspension has been issued based on medical advice received by NZMMAF and is intended to protect your health and wellbeing, as well as uphold the safety and integrity of competition.

*This suspension applies to **all NZMMAF-sanctioned bouts, training events, and activities**, and will remain in effect until you are cleared by an appropriate medical professional and NZMMAF has reviewed and accepted that clearance.*