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MEDLIC, LLC  
ALL INCLUSIVE DOCTOR OR BUSINESS AGREEMENT

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This All Inclusive Doctor/Business Agreement ("Agreement") is made and effective on \_\_\_\_\_ by and between MedLic, LLC ("Owner") and \_\_\_\_\_ ("Recipient").

This signed contract will be used with the intent to add the ("Recipient") to the ("Owner's") nationwide Directory of Doctors which is solely used by Amateur and Professional Athletes ("Athlete") in the boxing, kickboxing and mixed martial arts industry. Athletes are required by all U.S. Territories, North American Tribal Athletic Commissions and Canadian Athletic Commissions to obtain a license in order to compete. The Recipient will be obligated to conduct all necessary exams, tests, procedures and/or forms that are requested by the ("Athlete") in order for them to obtain their competitive license.

As per this agreement:

- ("Owner") will not charge the Recipient any fees to be added to the nationwide directory.
- ("Owner") will not add additional fees on top of submitted price from that doctor's office.
- All listed rates for services rendered by ("Recipient") must be honored at the time of visit by Athlete per in this agreement.
- All fees paid by Athlete will be a cash or credit card only payment at the time of service, unless otherwise noted.
- If, at any time, the ("Recipient") chooses to be removed from the nationwide directory, the Recipient must give 30 days written notice to Owner.
- It is noted that Athletes will ONLY be seen by a licensed M.D. or D.O. unless otherwise stated in this agreement.
- ("Owner") reserves the right that the ("Recipient") must honor the time and date of the athlete's appointment if it was made by Athlete before the written notice was received. ("Owner") will remove ("Recipient") from directory after the 30 days.
- ("Owner") reserves the right to cancel agreement at will due to negligence, improper treatment by ("Recipient") or ("Recipient's") staff; and/or conduct to Athlete.
- If the Athlete consents to his/her medical records to be released to ("Owner"), the ("Recipient") has the choice to have the Athlete sign Recipients Release form and have the Athlete's documents sent to ("Owner"). ("Recipient") will forward all needed medical records to ("Owner") after appointment is complete and release form is signed.



**NOTE:** Please sign below in Blue ink ONLY, and mail or scan (scanning must be able to show signature in blue ink) original document, along with our questionnaire to MedLic, LLC at: 924 Palmhurst Drive, Las Vegas, NV 89145.

Business Name: \_\_\_\_\_

Business Owner's Printed Name: \_\_\_\_\_

Business Owner Signature: \_\_\_\_\_

**Note:** This section only needs to be signed if you are not a doctor's office.

Print Doctor Name: \_\_\_\_\_

Doctor Signature: \_\_\_\_\_

Name of clinic or facility: \_\_\_\_\_

Date: \_\_\_\_\_

State & License #: \_\_\_\_\_



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MEDLIC, LLC  
MEDICAL DOCTOR QUESTIONNAIRE

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**Please fill out all required information that you would like added to MedLic's doctor directory.**

**NOTE:** All doctors must be a licensed M.D., or D.O.

**Field of Medicine:** Example (Sports Medicine, Family Doctor, etc.) **NOTE: License # will not be displayed on the directory. It is for commission use ONLY.**

Name: \_\_\_\_\_ MD: \_\_\_\_\_ DO: \_\_\_\_\_

State and License # \_\_\_\_\_

Field of Medicine: \_\_\_\_\_

Please specify if you are Board Certified: Yes: \_\_\_\_\_ or No: \_\_\_\_\_

**Name of Clinic or Facility:** \_\_\_\_\_

Physical Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

(Please specify if the same)

County: \_\_\_\_\_

Office Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Office E-mail: \_\_\_\_\_

**(NOTE: needed for e-mail confirmations and courtesy updates ONLY.)**

Name of Direct Contact: \_\_\_\_\_

Direct Contact's direct line: \_\_\_\_\_

Direct Contact's E-mail: \_\_\_\_\_

Hours of Operation: \_\_\_\_\_

**(Please list the time above, if the office is closed for lunch.)**



Non days of operation (Holidays observed): \_\_\_\_\_  
\_\_\_\_\_

Contact person when fighter makes appointment: \_\_\_\_\_

Languages Spoken: \_\_\_\_\_

**If you have more than one location, please add as many locations as you would like listed in the directory.**

**Location #2 Address:**

Physical Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

(Please specify if the same)

County: \_\_\_\_\_

Office Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Office E-mail: \_\_\_\_\_

**(NOTE: needed for e-mail confirmations and courtesy updates ONLY.)**

Name of Direct Contact: \_\_\_\_\_

Direct Contact's direct line: \_\_\_\_\_

Direct Contact's E-mail: \_\_\_\_\_

Hours of Operation: \_\_\_\_\_

**(Please list the time above, if the office is closed for lunch.)**

Non days of operation (Holidays observed): \_\_\_\_\_  
\_\_\_\_\_

Contact person when fighter makes appointment: \_\_\_\_\_

**Location #3 Address:**

Physical Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

(Please specify if the same)

County: \_\_\_\_\_



Office Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Office E-mail: \_\_\_\_\_

**(NOTE: needed for e-mail confirmations and courtesy updates ONLY.)**

Name of Direct Contact: \_\_\_\_\_

Direct Contact's direct line: \_\_\_\_\_

Direct Contact's E-mail: \_\_\_\_\_

Hours of Operation: \_\_\_\_\_

**(Please list the time above, if the office is closed for lunch.)**

Non days of operation (Holidays observed): \_\_\_\_\_

\_\_\_\_\_

Contact person when fighter makes appointment: \_\_\_\_\_

**Appointments needed?** Yes \_\_\_\_\_ No \_\_\_\_\_

**Walk-ins accepted?** Yes \_\_\_\_\_ No \_\_\_\_\_

**Payment type accepted:** Visa \_\_\_\_ MC \_\_\_\_ AmEx \_\_\_\_ Discover \_\_\_\_ Money Order \_\_\_\_  
Cash \_\_\_\_ Personal Check \_\_\_\_ Cashiers Check \_\_\_\_ Debit Card \_\_\_\_\_

**(NOTE: All discounted rates per MedLic's Agreement will apply, unless the doctor's office chooses to accept the Athlete's personal insurance information. MedLic assumes no responsibility for any outstanding debt the Athlete may incur. Accepting insurance from an Athlete voids this contract and agreement for current appointment ONLY.)**

**If your office conducts pregnancy tests, please specify.**

**Urine:** \_\_\_\_\_ Yes: \_\_\_\_\_ No: \_\_\_\_\_

MedLic's Contracted Price: \$ \_\_\_\_\_

Doctor's Original Price: \$ \_\_\_\_\_

**Blood:** \_\_\_\_\_ Yes: \_\_\_\_\_ No: \_\_\_\_\_

MedLic's Contracted Price: \$ \_\_\_\_\_

Doctor's Original Price: \$ \_\_\_\_\_



**List of services and prices contracted for MedLic, LLC.**

Exam: \_\_\_\_\_

MedLic's Contracted Price: \$ \_\_\_\_\_

Doctor's Original Price: \$ \_\_\_\_\_

Exam: \_\_\_\_\_

MedLic's Contracted Price: \$ \_\_\_\_\_

Doctor's Original Price: \$ \_\_\_\_\_

Exam: \_\_\_\_\_

MedLic's Contracted Price: \$ \_\_\_\_\_

Doctor's Original Price: \$ \_\_\_\_\_

Exam: \_\_\_\_\_

MedLic's Contracted Price: \$ \_\_\_\_\_

Doctor's Original Price: \$ \_\_\_\_\_

Exam: \_\_\_\_\_

MedLic's Contracted Price: \$ \_\_\_\_\_

Doctor's Original Price: \$ \_\_\_\_\_

**Please indicate if you are able to do Lab work in your office:**

Yes: \_\_\_\_\_ No: \_\_\_\_\_

Please disregard the following questions if answered NO.

HIV:

MedLic's Contracted Price: \$ \_\_\_\_\_

Doctor's Original Price: \$ \_\_\_\_\_

Hepatitis BsAg(surface antigen):

MedLic's Contracted Price: \$ \_\_\_\_\_

Doctor's Original Price: \$ \_\_\_\_\_

Negative Hepatitis CAb (surface antibody):

MedLic's Contracted Price: \$ \_\_\_\_\_

Doctor's Original Price: \$ \_\_\_\_\_

All three (as a package deal) \$ \_\_\_\_\_



Please submit prices for tests listed below or if you have a list of all types of blood test your office provides, please attach and forward to [info@mymedlic.com](mailto:info@mymedlic.com) along with MedLic's contracted prices showing.

Pt/Ptt: (Blood clotting)

MedLic's Contracted Price: \$\_\_\_\_\_

Doctor's Original Price: \$\_\_\_\_\_

CBC: (Blood Count)

MedLic's Contracted Price: \$\_\_\_\_\_

Doctor's Original Price: \$\_\_\_\_\_

TB: (Tuberculosis)

MedLic's Contracted Price: \$\_\_\_\_\_

Doctor's Original Price: \$\_\_\_\_\_

**By signing this document, you are agreeing and allowing MedLic, LLC to list the contracted prices above in their directory.**

Print Name: \_\_\_\_\_

Doctor Signature: \_\_\_\_\_

Date: \_\_\_\_\_

