# Arkansas Department of Health

4815 West Markham Street ● Little Rock, Arkansas 72205-3867 ● Telephone (501) 661-2000
**Governor Asa Hutchinson**
**Nathaniel Smith, MD, MPH, Director and State Health Officer**

August 20, 2018

Greetings

This letter provides official notification of wrestling licensure and blood work requirements. This is effective as of the August 7, 2018 Athletic Commission meeting.

- All wrestlers are to be licensed, including those participating in charitable events
- All wrestling promoters are to be licensed, including those promoting charitable wrestling events
- All wrestlers are required to provide the required blood tests results
- Wrestlers (and only wrestlers) blood test results will be considered valid for 12 months
    - Blood tests required: HIV 1 & 2, Hepatitis BsAg, and Hepatitis C
    - Blood test results are only accepted from the original source (laboratory or medical provider) or approved commissions. As of this letter Virginia and Ohio Athletic Commissions are approved. Results are to be sent directly to Arkansas Athletic Commission office.
    - Fax: 501-255-0394
    - Email: Arkansas.State.Athletic.Commission@arkansas.gov
    - A release to the Arkansas Department of Health/Athletic Commission Form is included with this notice

This notice is available on the Arkansas Department of Health Athletic Commission web page. Below is the link
https://www.healthy.arkansas.gov/programs-services/topics/arkansas-state-athletic-commission

Respectfully,


Athletic Commission Office

# Direct Release of Test Results to
# Arkansas Department of Health/ Arkansas Athletic Commission

I _____ (print patient name) authorize and instruct the laboratory or medical provider to issue/release the following lab test results via fax or email to:

Arkansas Athletic Commission/Arkansas Department of Health
       Fax number: (501) 255-0394
       Email: [Arkansas.State.Athletic.Commission@arkansas.gov](mailto:Arkansas.State.Athletic.Commission@arkansas.gov)

**Required Test Results to be submitted**
Hepatitis BsAg
Hepatitis C
Hepatitis C confirmation if performed
HIV 1 & 2

_____  _____
Patient Signature                     Date