OPHTHALMOLOGICAL EXAMINATION

Only a licensed Ophthalmologist or Optometrist may conduct this examination and complete this form.

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY

Applicant Information

Last Name		First Name		Middle Name	
DOB		SS Number		Date	

Examination

Vision:	Without Correction	With Correction
Right		
Left		

Refraction: If either eye is 20/40 or worse:							
Right		Sph		Cyl x		Acuity	
Left		Sph		Cyl x		Acuity	

Slit Lamp Exam		Normal Right	Normal Left	Abnormal Right	Abnormal Left	Specific Abnormalities
Conjuctiva Cornea						
Iris/Pupil						
Lens						
Eyelid						

Direct Opthalmoscopy (Dilated Pupil)

	Normal Right	Normal Left	Abnormal Right	Abnormal Left	Specific Abnormalities
Disc					
Macula					
Vessels					
Peripheal Retina					

I hereby certify that based on the participant's medical history, my physical findings and pending any medical testing not yet reviewed, it is my opinion that said participant is in good physical condition and ☐**IS** or ☐**IS NOT** medically cleared to be licensed as a competitor in combative sports such as Boxing, Kickboxing or Mixed Martial Arts.

Reason if Participant is not cleared for competition: ____

_________________________ Physician's Name

_________________________ Signature

_________________ Date