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OFFICE OF
COMBATIVE SPORTS

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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 _____ Date of Birth _____

Examination:

Vision:	Without	With Glasses		Refraction: If either eye is 20/40 or worse:							
Right				Right		Sph		Cyl x		Acuity	
Left				Left		Sph		Cyl x		Acuity	

Remarks: _____

Intraocular Tension — Right _____ mmHg; Left _____ mmHg

Motility — Normal _____ abnormal _____

Binocular vision — Normal _____ Abnormal _____

Slit Lamp Exam		Normal		Abnormal		Specific Abnormalities
Conjunctiva Cornea		Right	Left	Right	Left	
Iris/Pupil						
Lens						
Eyelids						

DIRECT OPHTHALMOSCOPY (Dilated Pupil)							
		Normal			Abnormal		Specific Abnormalities
		Right	Left		Right	Left	
Disc							
Macula							
Vessels							
Peripheral 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** ☐ **IS NOT** medically cleared to be licensed as a competitor in professional boxing/MMA.

Reason if not cleared for competition: _____

_____

_____ _____ _____ _____

Physician's Name, M.D./D.O. Signature License No. Exam Date

_____ _____

Email Phone