

OPHTHALMOLOGICAL EXAMINATION

Only a licensed ophthalmologist or optometrist may conduct this examination and complete this form.

APPLICANT INFORMATION

Last name	First name	Middle name	Date of birth
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EXAMINATION

Vision	Without	With glasses	Refraction: If either eye is 20/40 or worse								
RIGHT											
LEFT											

Remarks: _____

Intraocular Tension Right _____ mmHg
 Intraocular Tension Left _____ mmHg
 Motility Normal _____ Abnormal _____
 Binocular vision Normal _____ Abnormal _____

Slit Lamp Exam	Normal		Abnormal		Specific abnormalities
	RIGHT	LEFT	RIGHT	LEFT	
Conjunctiva cornea					
Iris/Pupil					
Lens					
Eyelids					

DIRECT Ophthalmoscopy (Dilated pupil)					
	Normal		Abnormal		Specific abnormalities
	RIGHT	LEFT	RIGHT	LEFT	
Macula					
Vessels					
Peripheral retina					

I hereby certify that based on 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/mixed martial arts. *State reason if not cleared for competition below:*

Physician's name, M.D P.A. Signature License number Date

Email Phone