



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	Left	Sph	Cyl x	Acuity			
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
		Right	Left	Right	Left	
Conjunctiva						
Cornea						
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 _____