APPLICANT NAME (Please Print) _____

MEDICAL EYE EXAM FOR COMBATIVE SPORTS

Exam with dilation must be done by an OPTHALMOLOGIST or OPTOMETRIST

Examination (normal-N; abnormal-X)	Right Eye	Left Eye
VISUAL ACUITY (WITHOUT CORRECTION)	N _____ F _____	N _____ F _____
EXTERIOR EXAM	_____	_____
ANTERIOR EXAM	_____	_____
FUNDI	_____	_____
EXTRACOCULAR MUSCLES	_____	_____
VISUAL FIELDS (Confrontation)	_____	_____
TONOMETRY	_____	_____

EXPLAIN ABNORMAL FINDINGS _____
_____
_____

DIAGNOSIS _____
_____
_____

I hereby certify that a dilated exam was performed on: _____
(Please print applicant's name)

Date of Exam: _____, _____ _____
Month Day Year

I HAVE APPROVED THIS PERSON TO PARTICIPATE IN A COMBATIVE SPORTS EVENT.

Ophthalmologist or Optometrist NAME _____
(Please Print)

LICENSE # _____
(Must be licensed in a State, District, or Territory of the United States)

ADDRESS _____ CITY _____

STATE _____ ZIP _____ PHONE NUMBER _____

OPHTHAMOLOGIST or
OPTHMETRIST SIGNATURE _____ DATE _____

APPLICANT SIGNATURE _____ DATE _____