

**CALIFORNIA STATE ATHLETIC COMMISSION**

2005 Evergreen Street, Suite 2010 | Sacramento, CA 95815

Phone: (916) 263-2195 | Fax: (916) 263-2197

Website: www.dca.ca.gov/csac | Email: csac@dca.ca.gov**PROFESSIONAL ATHLETE OPHTHALMOLOGIC EXAMINATION**

Only a licensed physician who specializes in ophthalmology may conduct this examination and complete this form. Please complete this form in its entirety.

NOTE TO PHYSICIAN: PLEASE EMAIL COMPLETED FORM TO csac@dca.ca.gov OR FAX TO (916) 263-2197.

SECTION 1. APPLICANT INFORMATION (to be completed by applicant)

First Name:	Middle:	Last:		
Address: <i>Street:</i>	<i>City:</i>	<i>State:</i>	<i>Zip:</i>	<i>Country:</i>
Home Telephone Number: ()	Cellular Telephone Number: ()	Email Address:		
Male / Female (Circle One)	Age:	Date of Birth: (MM/DD/YY)		

SECTION 2. EYE HISTORY (to be completed by applicant)**Circle one**

Have you ever had blurred vision (not corrected by glasses or contact lenses)?	YES	NO
Have you ever had any surgical procedures done to your eye(s) or the tissues around your eye(s) other than simple sutures of the skin around the eye (including LASIK)? If yes, please explain in full:	YES	NO
Have you ever been diagnosed by a physician to have significant eye problems such as retinal detachment, retinal tear, glaucoma, lens or cataract removal, lens implant, keratoconus or dislocated lens? If yes, please explain in full:	YES	NO
Have you ever had any eye disease? If yes, list nature of diseases or injuries:	YES	NO
Have you ever had any eye injury? If yes, list nature of diseases or injuries:	YES	NO
Retinal re-attachment? If yes, please explain:	YES	NO

SECTION 3. EXAMINATION VISION (to be completed by examining ophthalmologist)

VISUAL ACUITY WITHOUT CORRECTION: Right _____ / _____ Left _____ / _____ Remarks: _____	VISUAL ACUITY WITH CORRECTION: Right _____ / _____ Left _____ / _____ Remarks: _____	VISUAL ACUITY WITH BOTH EYES WITHOUT CORRECTION (known as binocular vision): _____ / _____ Remarks: _____
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ATHLETIC OPHTHALMOLOGIC EXAMINATION
 APPLICANT NAME: _____

SECTION 3. EXAMINATION VISION (continued)

SLIT LAMP EXAM

	NORMAL Right/Left	ABNORMAL Right/Left	SPECIFY ABNORMALITIES
Conjunctiva Cornea: _____	_____/____	_____/____	_____
Iris/Pupil: _____	_____/____	_____/____	_____
Lens: _____	_____/____	_____/____	_____
Eyelids: _____	_____/____	_____/____	_____

INDIRECT OPHTHALMOSCOPY WITH SCLERAL DEPRESSION (Dilated Pupil)

	NORMAL Right/Left	ABNORMAL Right/Left	SPECIFY ABNORMALITIES
Disc: _____	_____/____	_____/____	_____
Macula: _____	_____/____	_____/____	_____
Lens: _____	_____/____	_____/____	_____
Peripheral Retina: _____	_____/____	_____/____	_____

Does the applicant have uncorrected visual acuity of less than 20/200 in either eye or 20/60 with both eyes (binocular vision)?	YES	NO
Does the applicant have corrected visual acuity of less than 20/60 in either eye, regardless of its cause?	YES	NO
Does the applicant have a visual field of 60 degrees or less extending over one or more quadrants of the visual field?	YES	NO
Is there a presence or history of retinal detachment or retinal tear?	YES	NO
Is there a presence of primary or secondary glaucoma?	YES	NO
Is there a presence of aphakia, pseudophakia, or any other visual condition which would prevent the applicant from safely engaging in combative sports?	YES	NO

Examining physician: Any of the above conditions **MUST** be reported immediately to the California State Athletic Commission. Please immediately forward a copy of any report, directly to the commission, for any applicant who has a condition that may preclude him/her from safely engaging in combative sports.

PHYSICIAN'S REMARKS:

PHYSICIAN STATEMENT: I have read the above criteria and, in accordance with the vision requirements as stated therein, have examined the applicant named on the this form and **in person.**

Based on my personal observation and review of the test results and conditions described above, is it my medical opinion that this applicant has no visual condition that might prevent the applicant from safely engaging in combative sports? If no, please explain:

YES NO

 OPHTHALMOLOGIST NAME (print) MEDICAL LICENSE NO.

 ADDRESS/CITY/STATE/ZIP CODE

 TELEPHONE NO.

 PHYSICIAN'S SIGNATURE

 DATE

 APPLICANT'S NAME (print)

 APPLICANT'S SIGNATURE

 DATE

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