



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)

Form with fields for First Name, Middle, Last, Address (Street, City, State, Zip, Country), Home Telephone Number, Cellular Telephone Number, Email Address, Male/Female, Age, and Date of Birth.

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

Table with 2 columns: Question and YES/NO. Questions include: Have you ever had blurred vision...? Have you ever had any surgical procedures...? Have you ever been diagnosed...? Have you ever had any eye disease...? Have you ever had any eye injury...? Retinal re-attachment...?

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

Table with 3 columns: VISUAL ACUITY WITHOUT CORRECTION, VISUAL ACUITY WITH CORRECTION, and VISUAL ACUITY WITH BOTH EYES WITHOUT CORRECTION. Includes fields for Right/Left vision and Remarks.

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:

<p>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. 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:</p> <p>_____</p>	<p>YES</p> <p>NO</p>
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<p>_____ OPHTHALMOLOGISTNAME (print) MEDICAL LICENSE NO.</p> <p>_____ ADDRESS/CITY/STATE/ZIP CODE</p> <p>_____ TELEPHONE NO.</p> <p>_____ PHYSICIAN'S SIGNATURE</p> <p>_____ DATE</p>	<p>_____ APPLICANT'S NAME (print)</p> <p>_____ APPLICANT'S SIGNATURE</p> <p>_____ DATE</p>
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