

UNITED STATES AMATEUR COMBAT ASSOCIATION

APPLICANT NAME (Please Print) _____

** OPHTHALMOLOGIC MEDICAL EXAM **

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	_____	_____
EXTRAOCULAR MUSCLES	_____	_____
VISUAL FIELDS (Confrontation)	_____	_____
TONOMETRY	_____	_____

EXPLAIN ABNORMAL FINDINGS _____

DIAGNOSIS _____

I hereby certify that I have examined _____
(please print applicant's name)

Date of the 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
OPTOMETRIST SIGNATURE _____ DATE _____

APPLICANT SIGNATURE _____ DATE _____