

ARIZONA BOXING AND MIXED MARTIAL ARTS COMMISSION

DILATED EYE EXAM

REPORT OF EYE EXAMINATION FOR PROFESSIONAL BOXER / UNARMED COMBATANT TO BE PERFORMED BY AN OPTOMETRIST OR OPHTHALMOLOGIST

Last Name _____ First Name _____ Middle _____ Date of Birth _____
Street Address _____ City _____ State _____ Zip _____

BOXER Boxing Record: _____ **MMA FIGHTER:** MMA Record: _____

HISTORY

If possible provide the following information:

Name and hometown of physician in charge: _____

Has applicant ever had any of the following conditions:

1. Blurred vision Yes No
2. Surgical procedures done to his/her eye(s) or the tissues around the eye other than simple sutures of the skin around the eye? Yes No
3. Has applicant ever been informed by a physician that he/she had significant eye problems such as retinal detachment, retinal tear, primary or secondary glaucoma, aphakia, pseudophakia, dislocated lens, or cataract? Yes No

If yes, please explain: _____

4. Eye disease: Yes No List nature of disease: _____

5. Eye injury: Yes No List nature of injury: _____

6. Detached retina surgery on either eye: Yes No
List which eye and when and where surgery was done: _____

EXAMINATION

VISION:	Without	With Glasses
Right		
Left		

REFRACTION: If either eye is 20/40 or worse:							
Right		Sph		Cyl x		Acuity	
Left		Sph		Cyl x		Acuity	

Intraocular Tension Right _____ mmHg

Left _____ mmHg

Motility Normal _____ Abnormal _____

Binocular Vision Normal _____ Abnormal _____

Remarks: _____

SLIT LAMP EXAM

NORMAL

ABNORMAL

SPECIFIC ABNORMALITIES

	Right	Left	Right	Left	
Conjunctiva					
Cornea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Iris/Pupil	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eyelids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

INDIRECT OPHTHALMOSCOPY WITH SCLERAL DEPRESSION (Dilated Pupil)

NORMAL

ABNORMAL

SPECIFIC ABNORMALITIES

	Right	Left	Right	Left	
Disc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Macula	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Vessels	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Peripheral Retina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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The Commission shall deny, suspend, revoke, or place restrictions on the license of a professional boxer or martial arts fighter because of a medical or visual condition, (The Commission may also place restrictions for the same medical conditions on all amateur combatants under its jurisdiction) including but not limited to the following:

1. Uncorrected visual acuity of less than 20/200 in either eye or 20/60 with both eyes;
2. Corrected visual acuity of less than 20/60 in either eye, regardless of its cause;
3. A visual field of 60 degrees or less extending over one or more quadrants of the visual field;
4. Presence or history of retinal detachment or retinal tear unless treated by an ophthalmologist and then approved by an ophthalmologist specified by the Commission who then assesses that the boxer is at no significant risk of further injury to the retina if boxing is resumed. Such assessment shall occur both within five days before and five days after the contest;
5. Presence of primary or secondary glaucoma, whether or not such condition has been treated;
6. Presence of aphakia, pseudophakia, dislocated lens or cataract in either eye;
7. Any other visual condition which the Commission determines would prevent the applicant or licensee from safely engaging in boxing activities.

The examining physician is requested to mail or fax a copy of any report, directly to the Commission of an applicant that has a condition that may preclude him/her from being licensed or cleared to participate in any combat activities.

REPORT OF EYE EXAMINATION FOR PROFESSIONAL BOXER / UNARMED COMBATANT
PHYSICIAN REMARKS:

OPTOMETRIST OR OPHTHALMOLOGIST MUST COMPLETE ALL ITEMS LISTED BELOW

I have read the above criteria and, in accordance with the vision requirements as stated therein, have examined the applicant named on page 1 and page 2 of this form and

I HAVE HAVE NOT medically cleared him/her to compete as a licensed boxer/unarmed combatant.

_____ PHYSICIAN NAME / LICENSE # (please print)			_____ PHYSICIAN SIGNATURE
_____ OFFICE NAME AND STREET ADDRESS			_____ DATE
_____ CITY	_____ STATE	_____ ZIP CODE	() _____ PHONE NUMBER

*** MEDICAL RELEASE AUTHORIZATION BY APPLICANT ***

I AUTHORIZE any physician to release to the Arizona Boxing and MMA Commission any of my medical records in his/her possession. I also authorize the Arizona Boxing and MMA Commission to release any medical information or other personal information with respect to my status and licensure as a professional boxer or unarmed combatant which may be contained in any of its records to other State Commissions. I agree that a photographic copy of this authorization shall be valid as the original. I agree that this authorization will be valid for a period of one year from the date indicated in this document.

_____ SIGNATURE OF APPLICANT	_____ DATE
_____ NAME PRINTED	() _____ PHONE NUMBER

ANY ATTEMPT TO ALTER OR FALSIFY THIS DOCUMENT WILL RESULT IN FORFEITURE OF LICENSE AND/OR PROSECUTION IN A CRIMINAL COURT OF LAW.