

ARIZONA BOXING AND MIXED MARTIAL ARTS COMMISSION

OPHTHALMOLOGICAL EXAM

REPORT OF EYE EXAMINATION FOR
PROFESSIONAL BOXER/UNARMED COMBATANT
TO BE PERFORMED
BY AN 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:

- Blurred vision Yes No
- 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
- 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: _____
- Eye disease: Yes No List nature of disease: _____
- Eye injury: Yes No List nature of injury: _____
- 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

Conjunctiva _____
Cornea _____
Iris/Pupil _____
Lens _____
Eyelids _____

NORMAL		ABNORMAL	
Right	Left	Right	Left
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

INDIRECT OPHTHALMOSCOPY WITH SCLERAL DEPRESSION (Dilated Pupil)

NORMAL

ABNORMAL

SPECIFIC ABNORMALITIES

Disc _____
Macula _____
Vessels _____
Peripheral Retina _____

NORMAL		ABNORMAL	
Right	Left	Right	Left
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

THE COMMISSION WILL ONLY ACCEPT ORIGINAL EXAM SIGNED AND DATED BY OPHTHALMOLOGIST

OPHTHALMOLOGICAL EXAM

PAGE 2

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 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 boxing activities.

REPORT OF EYE EXAMINATION FOR PROFESSIONAL BOXER / UNARMED COMBATANT BY AN OPHTHALMOLOGIST

OPHTHALMOLOGIST REMARKS:

EXAMINATIONS BY AN OPTOMETRIST WILL NOT BE ACCEPTED

OPTOMETRISTS PLEASE DO NOT COMPLETE EYE EXAMINATION

OPHTHALMOLOGIST:

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

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

LICENSED OPHTHALMOLOGIST NAME AND LICENSE NUMBER (please print)

OPHTHALMOLOGIST SIGNATURE

STREET ADDRESS

DATE

CITY

STATE

ZIP CODE

() _____
PHONE NUMBER

APPLICANT:

SIGNATURE OF CONTESTANT

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.