OHIO ATHLETIC COMMISSION
242 FEDERAL PLAZA WEST
SUITE 405
YOUNGSTOWN, OH 44503
OFFICE: (330)-797-2556 FAX (330) 797-2559

OPHTHALMOLOGICAL EYE EXAM

Performed by an ophthalmologist, optometrist or qualified physician

NAME: (Last First Middle) | Ring Name | Date of Birth / / | Age

ADDRESS: (Street City State Zip Code) | Social Security Number XXX-XX-

HISTORY: - HAS APPLICANT HAD ANY OF THE FOLLOWING CONDITIONS:

(1) Blurred Vision? ☐ YES ☐ NO

(2) Surgical Procedures done to either of their eyes such as Lasik surgery; Lens Implants; or orbital floor reconstruction? ☐ YES ☐ NO

(3) Has applicant ever been informed by any physician that they had significant eye problems such as retinal detachment, retinal tear, primary or secondary glaucoma, aphakia, pseudophakia, dislocated lens, or catartact? ☐ YES ☐ NO
If YES, 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 where and when surgery was performed:_____

EXAMINATION:

VISION: With glasses or contacts | Without

Right _____ | _____

Left _____ | _____

REFRACTION: If either eye is 20/40 or worse
Right_____Sph_____Cyl x_____ Acuity_____
Left _____Sph_____ Cyl x_____ Acuity _____

Intraoccular Tension Right_____mmHG
Left _____mmHG

REMARKS: _____

Motility Normal _____ Abnormal _____

Binocular Vision Normal_____ Abnormal _____

SLIT LAMP EXAM	NORMAL Right	NORMAL Left	ABNORMAL Right	ABNORMAL Left	SPECIFY ABNORMAILITIES
Conjunctive Cornea					
Iris/Pupil					
Lens					
Eyelids					

INDIRECT OPHTHALMOSCOPY WITH SCLERAL DEPRESSION (Dilated pupil)

	NORMAL Right	NORMAL Left	ABNORMAL Right	ABNORMAL Left	SPECIFY ABNORMAILITIES
Disc					
Mascula					
Vessels					
Peripheral Retina					

OPHTHALMOLOGICAL EYE EXAM

PHYSICIAN'S REMARKS: _____

The commission shall deny, suspend, revoke or place restrictions on the license of any applicant applying for a professional license to participate in boxing, tough person, kick boxing, karate, mixed martial arts or any striking sports regulated by the Ohio Athletic Commission, because of any medical or visual condition, including but limited to the following:

(1) If applicat has had Lasik surgery performed. PRK eye surgery is acceptable.
(2) Uncorrected visual acuity of less than 20/200 in either eye or 20/60 with both eyes.
(3) Corrected visual acuity of less than 20/60 in either eye, regardless of its cause.
(4) A visual field of 60 degrees or less extending over one or more quandrants of the visual field.
(5) Presence or history of retinal detachment or retinal tear unless treated and approved by an Retinal Surgeon or a Retinal Specialist who then assess that by ophthamologist specified by the commission who then assess that the applicant is at no significant risk of any further injury to the retinal portion of the eye if the applicant participates in unarmed combat sports.
(6) Presence of primary or secondary glaucoma, whether or not such condition has been treated. A written clearance from an Ophthamologist that is qualified as a glaucoma specialist stating that there is no eveidence of any angle recession: uncontyrolled glaucoma; or visual compromise from nerve damage.
(7) Presence of aphakia, pseudophakia, dislocated lens or cataract in either eye.
(8) Any other visual condition which the commission determines would prevent the applicant or licensee from safely participating in any of the sports regulated by the commission.

The examining physician is requested to mail a copy of any report, directly to the commission of any applicant that has a condition that may preclude them from being licensed.

PHYSICIAN:

I have read the above criteria and in accordance with the vision requirements as stated therein, I have examined the applicant named on page 1 of this eye examination form and find no condition that would preclude them from being licensed to participate in boxing, tough person, kick boxing, karate, mixed martial arts or any other type of unarmed combat sport.

Licensed Physician's name (please print)	Physician's license number	Physician's signature
( ) Phone Number		Date

APPLICANT:

I declare under penalty of perjury under the laws of the state of Ohio that the foregoing information is true and correct; further I realize that any intentional misrepresentation may result in disciplinary action against my license.

I hereby **AUTHORIZE** the Ohio Athletic Commission and or any physician employed by the Ohio Athletic Commission to **RELEASE** any and all medical information and/or personal information with respect to my status and licensure as a professional athlete which may contain any of the Commission's records. I further authorize the Commission to **RELEASE** this information to any person whom the Commission determines has a need to know. I AGREE that I will fully cooperate with the Commission in making my medical history available including but not limited to giving oral or written reports to the Commission regarding my medical condition, care, and/or treatment.

I further **RELEASE, PROMISE TO HOLD HARMLESS, AND COVENANT NOT TO SUE** the Commission or any representative of the Commission on the basis of its attempts to obtain any of the foregoing information, and I further **RELEASE, PROMISE TO HOLD HARMLESS, AND COVENANT NOT TO SUE** any persons, firms, institutions or agencies providing such information to representatives of the Athletic Commission on the basis of its disclosures. I have signed the release voluntarily and of my own free will.

I further agrree that a photographic copy of this AUTHORIZATION shall be valid as the original.

Applicant Name (Print)	Applicant Signature	Date