OREGON STATE ATHLETIC COMMISSION
500 Airport Rd SE Salem, OR 97301
Phone: 503-871-5091 Fax: 503-540-1440
Email: osac@osp.oregon.gov

Unarmed Combat Sports Competitor Eye Exam

Only a licensed physician who specializes in Ophthalmology or Optometry may conduct this examination and complete this form. Please complete this form in its entirety.

SECTION 1. APPLICANT INFORMATION (to be completed by applicant)				
First Name:	**Middle:**	**Last:**		
Address: *Street:*	*City:*	*State:*	*Zip:*	*Country:*
Cell Phone Number: ( )	**Secondary Contact:** ( )	**Email Address:**		
Male / Female (Circle One)	**Age:**	**Date of Birth: (MM/DD/YY)**		

SECTION 2. EYE HISTORY *(to be completed by applicant)*	**Circle one**
Have you ever had blurred vision (not corrected by glasses or contact lenses)?	**YES** ☐ **NO** ☐
Have you ever had any surgical procedures done to your eye(s) or the tissues around your eye(s) other than simple sutures of the skin around the eye (including LASIK)? If yes, please explain in full:	**YES** ☐ **NO** ☐
Have you ever been diagnosed by a physician to have significant eye problems such as retinal detachment, retinal tear, glaucoma, lens or cataract removal, lens implant, keratoconus or dislocated lens? If yes, please explain in full:	**YES** ☐ **NO** ☐
Have you ever had any eye disease? If yes, list nature of diseases or injuries:	**YES** ☐ **NO** ☐
Have you ever had any eye injury? If yes, list nature of diseases or injuries:	**YES** ☐ **NO** ☐
Retinal re-attachment? If yes, please explain:	**YES** ☐ **NO** ☐

SECTION 3. EXAMINATION VISION *(to be completed by Optometrist or Ophthalmologist)*		
VISUAL ACUITY WITHOUT CORRECTION: Right _____/_____ Left _____/_____ Remarks: _____	**VISUAL ACUITY WITH SOFT CONTACT CORRECTION**: Right _____/_____ Left _____/_____ Remarks:_____	**VISUAL ACUITY WITH BOTH EYES (known as binocular vision)**: _____/_____ corrected _____/_____ uncorrected Remarks: _____

Rev. 03/18/20

Athletic Vision Examination

Applicant Name:

SECTION 3: VISION EXAM & EYE HEALTH

	Right Eye (OD)		Left Eye (OS)		
	Normal	Abnormal	Normal	Abnormal	Specify Abnormalities:
Lids/Adnexa:					
Conjunctiva:					
Cornea:					
Iris/Pupil:					
Lens:					
Optic Nerve:					
Macula:					
Vessels:					
Periphery:					

FOR VISUAL ACUITY, TEST AT A DISTANCE OF 30 INCHES (APPROX 76 CM)

Does the applicant have uncorrected visual acuity of 20/**200** or less in either eye, or 20/60 or less with both eyes?	**YES** ☐ **NO** ☐
Does the applicant have best corrected visual acuity of 20/60 or less in either eye?	**YES** ☐ **NO** ☐
Does the applicant have less stereopsis than 100 seconds? (Numerically >100 seconds) **Measured at 16 inches/40 cm**	**YES** ☐ **NO** ☐
Does the applicant have a visual field defect in any quadrant?	**YES** ☐ **NO** ☐
Is there a presence or history of retinal tear or detachment in either eye?	**YES** ☐ **NO** ☐
Is there a presence or history of glaucoma, aphakia, pseudophakia, or any other visual condition that would prevent the applicant from participating in combative sports?	**YES** ☐ **NO** ☐

Examining Provider: Any of the above conditions MUST be reported immediately to the Oregon State Athletic Commission. Please 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.

Provider's Comments:

_____

_____

Provider's Statement: I have read the above criteria, and in accordance with the vision standards stated therein, have examined the applicant named on this form.

Based on my medical observation and review of the test results and conditions described above, it is my professional opinion that this applicant has no ocular condition that might prevent him/her from safely engaging in combative sports. **YES** ☐ **NO** ☐

If NO, please explain: _____

Provider's Name:_____ **Provider Type (Circle One):** Optometrist/Ophthalmologist

Address:_____ **Phone:**_____

License Number/State:_____ **Applicant Name (Print):**_____

Date:

Provider's Signature: **Applicant Signature:**