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 EYE EXAMINATION

APPLICANT NAME: _____

SECTION 3. EXAMINATION VISION *(continued)*

	NORMAL Right/Left	ABNORMAL Right/Left	SPECIFY ABNORMALITIES
Conjunctiva Cornea:_____	_____/_____	_____/_____	_____
Iris/Pupil:_____	_____/_____	_____/_____	_____
Lens: _____	_____/_____	_____/_____	_____
Eyelids: _____	_____/_____	_____/_____	_____
Disc: _____	_____/_____	_____/_____	_____
Macula:_____	_____/_____	_____/_____	_____
Peripheral Retina: _____	_____/_____	_____/_____	_____
Vessels: _____	_____/_____	_____/_____	_____

Does the applicant have uncorrected visual acuity of less than 20/200 in either eye or 20/60 with both eyes (binocular vision)?	**YES**	**NO**
Does the applicant have corrected visual acuity of less than 20/60 in either eye, regardless of its cause?	**YES**	**NO**
Does the applicant have a visual field of 60 degrees or less extending over one or more quadrants of the visual field?	**YES**	**NO**
Is there a presence or history of retinal detachment or retinal tear?	**YES**	**NO**
Is there a presence of primary or secondary glaucoma?	**YES**	**NO**
Is there a presence of aphakia, pseudophakia, or any other visual condition which would prevent the applicant from safely engaging in combative sports?	**YES**	**NO**

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

PHYSICIAN'S REMARKS:

_____

PHYSICIAN STATEMENT (Optometrist or Ophthalmologist) : I have read the above criteria and, in accordance with the vision requirements as stated therein, have examined the applicant named on the this form. ***Based on my personal observation and review of the test results and conditions described above, is it my medical opinion that this applicant has no visual condition that might prevent the applicant from safely engaging in combative sports? If no, please explain:***	**YES**	**NO**

Exam Date: _____

_____ _____

PHYSICIAN'S NAME (print) MEDICAL LICENSE NO.

_____

ADDRESS/ CITY/ STATE/ ZIP CODE

_____

TELEPHONE NO.

_____

PHYSICIAN'S SIGNATURE DATE

_____

APPLICANT'S NAME (print)

_____

APPLICANT'S SIGNATURE DATE

Rev. 12/19