



California State Athletic Commission
 2005 Evergreen St. Ste. 2010
 Sacramento, CA 95815
 www.dca.ca.gov/csac/
 (916) 263-2195 FAX (916) 263-2197



PROFESSIONAL ATHLETE OPHTHALMOLOGIC EXAMINATION

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

BOXING

MIXED MARTIAL ARTS

KICKBOXING

Office Use Approved by: _____ Date: _____
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First	Middle	Last	Telephone	Date of Birth
Address	City	State	Zip Code	Country

HISTORY – Please provide the following information:

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 had or 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 diseases or injuries: _____
5. Eye Injury? **Yes No** List nature of diseases or injuries: _____
6. Retinal re-attachment? **Yes No** If yes, please explain: _____
7. Does the applicant have any other visual condition that would prevent him/her from safely engaging in boxing or martial arts activities? **Yes No** If yes, please explain: _____

EXAMINATION

VISION: Without / With Glasses
 Right _____ / _____
 Left _____ / _____
 Remarks: _____

REFRACTION: If either eye is 20/60 or worse:
 Right _____ Sph _____ Cyl x _____ Acuity _____
 Left _____ Sph _____ Cyl x _____ Acuity _____
 Intraocular Right _____ mmHg
 Tension Left _____ mmHg
 Motility Normal _____ Abnormal _____
 Binocular Vision Normal _____ Abnormal _____

SLIT LAMP EXAM	NORMAL	ABNORMAL	SPECIFY ABNORMALITIES
	Right/Left	Right/Left	
Conjunctiva	/	/	_____
Cornea	/	/	_____
Iris/Pupil	/	/	_____
Lens	/	/	_____
Eyelids	/	/	_____

ATHLETE OPHTHALMOLOGIC EXAMINATION

APPLICANT NAME: _____

INDIRECT OPHTHALMOSCOPY WITH SCLERAL DEPRESSION (Dilated Pupil)			
	NORMAL	ABNORMAL	SPECIFY ABNORMALITIES
	Right/Left	Right/Left	
Disc _____	/	/	_____
Macula _____	/	/	_____
Lens _____	/	/	_____
Peripheral Retina _____	/	/	_____

Title 4, Rules and Regulations, §282 states: The commission **shall** deny, suspend, revoke, or place restrictions on the license of a professional or amateur boxer or martial arts fighter because of a medical or visual condition, including but not limited to one of 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.

Examining physician: Any of the above conditions **MUST** be reported immediately to the Commission. **DO NOT** clear the applicant to compete if the applicant has one or more of the above symptoms. 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 being licensed.

PHYSICIAN STATEMENT: I have read the above criteria and, in accordance with the vision requirements as stated therein, have examined the applicant named on the other side of this form.

PHYSICIAN'S REMARKS: _____

Based on your personal observation and review of the test results and considering Commission Rule 282 above, is it your medical opinion that this applicant is physically fit to be licensed and compete in combative sports? **Yes No**
If no, please explain: _____

LICENSED PHYSICIAN'S NAME (print) **MEDICAL LICENSE NUMBER**

ADDRESS **CITY** **STATE** **ZIP CODE**

TELEPHONE NUMBER **DATE/TIME**

PHYSICIAN'S SIGNATURE