

NEVADA STATE ATHLETIC COMMISSION
 555 E. WASHINGTON AVENUE, SUITE 3200
 LAS VEGAS, NV 89101
 TELEPHONE (702) 486-2575 FACSIMILE (702) 486-2577

OPHTHALMOLOGIC EXAM
FOR PROFESSIONAL BOXER/UNARMED COMBATANT
EXAMINATIONS DONE BY AN OPTOMETRIST WILL NOT BE ACCEPTED
COMBATANTS CAN NOT COMPETE WITH CONTACT LENSES OR GLASSES

Full Name: First _____ Middle _____ Last _____ Ringname _____ (Telephone) _____ / / _____ Date of Birth

Address (street) _____ (city) _____ (state) _____ (zip code) _____

HISTORY - If possible provide the following information:

Name and hometown of physician in charge: _____

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 If yes, please explain: _____
- (3) 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: _____
- (4) Eye Disease? Yes No
 List nature of diseases or injuries: _____
- (5) Eye Injury? Yes No
 List nature of diseases or injuries: _____
- (6) Detached retina surgery on either eye? Yes No
 List which eye and when and where surgery was done: _____
- (7) Lasik Surgery on either eye? Yes No
 List which eye and when and where surgery was done: _____

EXAMINATION

VISION: Without / Best Correction	If either eye is 20/40 or worse with best correction
Right _____ / _____	Right _____ Sph _____ Cyl x _____ Acuity _____
Left _____ / _____	Left _____ Sph _____ Cyl x _____ Acuity _____

Remarks: _____

	Intraocular Tension	Right _____ mmHg	Left _____ mmHg	
	Motility	Normal _____	Abnormal _____	
	Binocular Vision	Normal _____	Abnormal _____	

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

INDIRECT OPHTHALMOSCOPY WITH SCLERAL DEPRESSION (Dilated Pupil)

	NORMAL Right/Left	ABNORMAL Right/Left	SPECIFY ABNORMALITIES
Disc _____	/	/	_____
Macula _____	/	/	_____
Vessels _____	/	/	_____
Peripheral Retina _____	/	/	_____

(PLEASE READ AND SIGN ON REVERSE SIDE OF EXAM)

OPHTHALMOLOGIC EXAM - Page Two

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

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.*

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.

PHYSICIAN'S REMARKS: _____

PHYSICIAN:

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 and

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

LICENSED PHYSICIAN'S NAME AND LICENSE NUMBER (please print)

PHYSICIAN'S SIGNATURE

STREET ADDRESS

DATE

CITY STATE ZIP CODE

() ()

TELEPHONE AND FAX NUMBER INCLUDING AREA CODE

APPLICANT:

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

I understand I CAN NOT wear glasses or contact lenses during competition.

I hereby AUTHORIZE the Athletic Commission of the Department of Business and Industry of the State of Nevada (the "Commission"), pursuant to the provisions of NRS/NAC Chapter 467, to RELEASE any and all medical information and/or personal information with respect to my status and licensure as a professional unarmed combatant which may be contained in 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 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 Commission on the basis of its disclosures. I have signed this Release voluntarily and of my own free will.

I further agree that a photographic copy of this Authorization shall be valid as the original.

Date

Signature of Applicant

Location

Name Printed