NEVADA STATE ATHLETIC COMMISSION
3300 W. SAHARA AVENUE, SUITE 450
LAS VEGAS, NV 89102
TELEPHONE (702) 486-2575 FACSIMILE (702) 486-2577

OPHTHALMOLOGIC EXAM

PROFESSIONAL UNARMED COMBATANT

EXAMINATIONS DONE BY AN OPTOMETRIST WILL NOT BE ACCEPTED

COMBATANTS CANNOT 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: Uncorrected visual acuity MUST be at least 20/200 in EACH EYE.

VISION: Without Correction

Right ____________________ Right ______Sph_____Cyl x_________Acuity_______________

Left ____________________ Left ______Sph_____Cyl x_________Acuity_______________

Intraocular Tension Right ____________________mmHg
Left ____________________mmHg

Motility Normal _____ Abnormal ______________

Binocular Vision Normal _____ Abnormal ______________

Remarks:____________________
____
____
____

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 UNARMED COMBATANT BY AN OPHTHALMOLOGIST

The commission may deny, suspend, revoke, or place restrictions on the license of a professional unarmed combatant because of a medical or visual condition, including but not limited to one of the following:

1) ***A visual field of 60 degrees or less extending over one or more quadrants of the visual field;***
2) ***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 unarmed combatant is at no significant risk of further injury to the retina if boxing is resumed;***
3) ***Presence of primary or secondary glaucoma, whether or not such condition has been treated;***
4) ***Presence of aphakia, pseudophakia, dislocated lens or cataract in either eye;***
5) ***Any other visual condition which the commission determines would prevent the applicant or licensee from safely engaging in unarmed combat.***

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 CANNOT 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