NEVADA STATE ATHLETIC COMMISSION
3300 W. SAHARA AVENUE, SUITE 450
LAS VEGAS, NV 89102-3200
TELEPHONE (702) 486-2575 FACSIMILE (702) 486-2577

VISION EXAMINATION
FOR OFFICIALS

_____ / ___ / _____
Full Name: First Middle Last (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: _____

The applicant must have best corrected vision of 20/40 or better to be licensed as an official.

EXAMINATION

VISION: Without Correction

Right _____ Right _____Sph_____Cyl x_____Acuity_____
Left _____ Left _____Sph_____Cyl x_____Acuity_____

OPTOMETRIST / PHYSICIAN REMARKS: _____
_____
_____

The examining optometrist/ 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.

OPTOMETRIST / PHYSICIAN:

I have read the above criteria and, in accordance with the vision requirements as stated therein, have examined the applicant named on this form and

I ☐ HAVE ☐ HAVE NOT medically cleared him/her to be an official.

_____ _____
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