ARIZONA BOXING AND MIXED MARTIAL ARTS COMMISSION

DILATED EYE EXAM

REPORT OF EYE EXAMINATION FOR
PROFESSIONAL BOXER / UNARMED COMBATANT
TO BE PERFORMED
BY AN OPTOMETRIST OR OPHTHALMOLOGIST

Last Name ____________ First Name ______________ Middle __________ Date of Birth ______

Street Address ______________________ City ________________ State ______ Zip ______

☐ **BOXER** Boxing Record: __________ ☐ **MMA FIGHTER**: MMA Record: __________

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
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 disease: ______________________________
5. Eye injury: ☐ Yes ☐ No List nature of injury: ______________________________
6. Detached retina surgery on either eye: ☐ Yes ☐ No
   List which eye and when and where surgery was done: ______________________________

EXAMINATION

VISION:	Without	With Glasses
Right		
Left		

REFRACTION: If either eye is 20/40 or worse:							
Right		Sph		Cyl x		Acuity	
Left		Sph		Cyl x		Acuity	

Intraocular Tension Right ______________ mmHg
Left ______________ mmHg

Motility Normal ________ Abnormal ________

Binocular Vision Normal ________ Abnormal ________

Remarks: ______________________________

SLIT LAMP EXAM		NORMAL Right	NORMAL Left	ABNORMAL Right	ABNORMAL Left	SPECIFIC ABNORMALITIES
Conjunctiva						
Cornea	________	☐	☐	☐	☐	________
Iris/Pupil	________	☐	☐	☐	☐	________
Lens	________	☐	☐	☐	☐	________
Eyelids	________	☐	☐	☐	☐	________

INDIRECT OPHTHALMOSCOPY WITH SCLERAL DEPRESSION (Dilated Pupil)

		NORMAL Right	NORMAL Left	ABNORMAL Right	ABNORMAL Left	SPECIFIC ABNORMALITIES
Disc	________	☐	☐	☐	☐	________
Macula	________	☐	☐	☐	☐	________
Vessels	________	☐	☐	☐	☐	________
Peripheral Retina	________	☐	☐	☐	☐	________

The Commission shall deny, suspend, revoke, or place restrictions on the license of a professional boxer or martial arts fighter because of a medical or visual condition, (The Commission may also place restrictions for the same medical conditions on all amateur combatants under its jurisdiction) including but not limited to 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 or fax a copy of any report, directly to the Commission of an applicant that has a condition that may preclude him/her from being licensed or cleared to participate in any combat activities.

REPORT OF EYE EXAMINATION FOR PROFESSIONAL BOXER / UNARMED COMBATANT
PHYSICIAN REMARKS:

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OPTOMETRIST OR OPHTHALMOLOGIST MUST COMPLETE ALL ITEMS LISTED BELOW

I have read the above criteria and, in accordance with the vision requirements as stated therein, have examined the applicant named on page 1 and page 2 of this form and

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

PHYSICIAN NAME / LICENSE # (please print) | PHYSICIAN SIGNATURE

OFFICE NAME AND STREET ADDRESS | DATE

CITY STATE ZIP CODE | ( ) PHONE NUMBER

* MEDICAL RELEASE AUTHORIZATION BY APPLICANT *

I AUTHORIZE any physician to release to the Arizona Boxing and MMA Commission any of my medical records in his/her possession. I also authorize the Arizona Boxing and MMA Commission to release any medical information or other personal information with respect to my status and licensure as a professional boxer or unarmed combatant which may be contained in any of its records to other State Commissions. I agree that a photographic copy of this authorization shall be valid as the original. I agree that this authorization will be valid for a period of one year from the date indicated in this document.

SIGNATURE OF APPLICANT | DATE

NAME PRINTED | ( ) PHONE NUMBER

ANY ATTEMPT TO ALTER OR FALSIFY THIS DOCUMENT WILL RESULT IN FORFIETURE OF LICENSE AND/OR PROSECUTION IN A CRIMINAL COURT OF LAW.