

FLORIDA ATHLETIC COMMISSION 2601 Blair Stone Road Tallahassee, Florida 32399-1016 PHONE: 850.488.8500 FAX: 850.922.2249 EMAIL: FAC@myfloridalicense.com

DILATED OPHTHALMOLOGICAL EXAMINATION (To be performed ONLY by an OPHTHALMOLOGIST or OPTOMETRIST)

To be completed by Participant (Fighter)

NAME: (LAST)	/EID	ST)	(MIDDLE)		
	•	,	, ,		
AGE: BIRT	TH DATE:/	/ SS#:			
HAVE YOU EVER HAD A		S? †YES †NO			
HAVE YOU EVER SUFF					
HAVE EITHER OF YOUF DETACHED RETINA OR					
EXAMINATION -	To be comple	ted by exami	ning Ophtha	lmologist or Op	tometrist
Date of Examination: _					
VISION: NAKED EYE:	_(LEFT) WIT _(RIGHT)	H CORRECTIVE L	.ENSES:	(LEFT) (RIGHT)	
REMARKS: ANY EVIDENCE OF PRE	ESENT OR FORME	R DISEASE? GIVE	SPECIFICS		_
					_
LEFT LIDS? : CONJUNCTIVA?:	7/ RIGHT	REMARKS			_
GLAUCOMA?:					- -
CORNEA? : PANNUS? :					- -
IRIS? : CHOROID? :					-
PTOSIS? :					-
RETINA? :	7		41.14	(D)	-
IF TRACHOMA IS PRES WHEN WAS IT LAST	ENT, IS IT ACTIVE	?:	(L)/	(R)	
DISCHARGE? :	_/				_
FOLLICIES? : CATARACT? :					
CORNEAL LEUCOMA?_					
PHYSICAL FIN	NDINGS, IT IS MY C	PINION THAT SAI	ID PARTICIPANT	THE PARTICIPANT A HAS A NORMAL EYE RTIAL ARTS MATCHI	EXAMINATION
☐ I HEREBY CEI	RTIFY THAT BASEI	ON THE STATE	MENTS MADE BY	THE PARTICIPANT A	ND/OR MY
				DOES NOT HAVE AN MARTIAL ARTS MAT	
SIGNATURE OF OPHTH	ALMOLOGIST/OP	TOMETRIST		PRINT) NAME OF MOLOGIST/OPTOME	TRIST
LICENSE NUMBER OF	OPHTHALMOLOGI	ST/OPTOMETRIS		HONE NUMBER OF	TRIST