ILLINOIS DEPARTMENT OF PROFESIONAL REGULATION
STATE OF ILLINOIS ATHLETIC UNIT
555 W. Monroe St., 8th floor
Chicago, IL 60661
Telephone 312.814.2721 Facsimile 217.557.8480

OPHTHALMOLOGIC EXAM

FOR PROFESSIONAL BOXER/FCMA CONTESTANT

ATTENTION CONTESTANTS: EXAMINATIONS CONDUCTED BY AN OPTOMETRIST WILL NOT BE ACCEPTED

CONTESTANTS CANNOT COMPETE WITH CONTACT LENSES OR GLASSES

Full Name: First Middle Last Date of Birth Telephone number

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

HISTORY - If possible provide the following information:
Name and city/town 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) PRK/Lasik Surgery on either eye? ☐ Yes ☐ No
List which eye and when and where surgery was done:_____

EXAMINATION

VISION: Without / Best Correction
Right _____/_____
Left _____/_____

If either eye is 20/40 or worse with **best correction**
Right _____Sph_____Cyl x_____Acuity_____
Left _____Sph_____Cyl x_____Acuity_____

Remarks: _____
_____
_____
_____

Intraocular Right _____mmHg
Tension 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)

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REPORT OF EYE EXAMINATION FOR PROFESSIONAL BOXER/FCMA CONTESTANT BY AN OPHTHALMOLOGIST

The Athletics Unit shall deny, suspend, revoke, or place restrictions on the license of a professional boxer or full contact martial arts contestant because of a medical or visual condition, including but not limited to one of the following:

1) ***Uncorrected visual acuity of 20/200 or less 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 will then assess whether or not the contestant is at no significant risk of further injury to the affected retina in order to compete as a contestant. Such assessment shall occur within five or more business days before 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 could prevent the applicant or licensee from safely engaging in boxing and/or FCMA competition.***

The examining physician is requested to mail a copy of any report, directly to the Athletics Unit 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 boxer/MMA contestant.

☐ **The patient presented a valid form of photo identification and I have personally verified his/her identity.**

_____ _____

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

_____ _____

STREET ADDRESS DATE

_____ (____) _____

CITY STATE ZIP CODE TELEPHONE NUMBER INCLUDING AREA CODE

APPLICANT:

I declare under penalty of perjury under the laws of the State of Illinois, 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 State of Illinois Athletic Unit ("Athletics") of the Department of Financial and Professional Regulation, to RELEASE any and all medical information and/or personal information with respect to my status and licensure as a professional boxer/FCMA contestant which may be contained in any of the Athletics' records. I further authorize Athletics to release this information to any person whom Athletics determines has a need to know. I agree that I will fully cooperate with Athletics in making my medical history available including, but not limited to, giving oral or written reports to Athletics regarding my medical condition, care and/or treatment.

_____ _____

Signature of Applicant Date

_____

Name (Printed)