VISION EXAMINATION
FOR OFFICIALS (REFEREES & JUDGES)

Access this form via website at: hawaii.gov/dcca/pvl

HAWAII MMA PROGRAM
P.O. BOX 3469
HONOLULU, HI 96801
TELEPHONE: (808) 586-2701
FAX: (808) 586-2874

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

Name (First, Middle, Last) _____ Phone No. _____ Date of Birth _____

Address (Include Apt. No., City, State and 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: _____

EXAMINATION

VISION: Without / With 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 _____

OPTOMETRIST/OPHTHALMOLOGIST REMARKS: _____

The examining optometrist/ophthalmologist is requested to mail a copy of any report, directly to the Hawaii MMA Program of an applicant that has a condition that may preclude him/her from being licensed.

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Name of Applicant: _____ Date: _____

OPTOMETRIST/OPHTHALMOLOGIST:

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 (Please Print)	PHYSICIAN'S LICENSE NO.
PHYSICIAN'S SIGNATURE	DATE
STREET ADDRESS	TELEPHONE NO. INCLUDING AREA CODE
CITY STATE ZIP CODE	FAX NO. INCLUDING AREA CODE

This material can be made available for individuals with special needs. Please call the Licensing Branch Manager at (808) 586-3000 to submit your request.