Eyesight Examination Form and Certificate

Applicant

Family Name(s)	Given Name(s)

Date of birth

Day		Month		Year			

Certifying medical practitioner / ophthalmologist:			
Name, qualifications and medical specialty (for example: Dr AB Cook, MD, General Practitioner:)			
Name			
Address			
Email			
Phone		Fax	
Mobile phone			
1.	Is the visual acuity 0.7 (6/9 or 20/30) or better on each eye? Yes, without correction ☐ Yes, but only with correction ☐ Corrections: Left: …… Right: ……..……		No ☐
2.	Is there any evidence or history of impaired night vision?		Yes ☐ No ☐
3.	Is there any defect in colour vision? If yes, what kind of defect:		Yes ☐ No ☐
4.	Is there any sign of diplopia?		Yes ☐ No ☐
5.	Are there any defects in the binocular visual field? If yes, attach vision field maps!		Yes ☐ No ☐
6.	Is there any evidence of other ophthalmic pathological conditions or diabetes? If yes, what condition(s):		Yes ☐ No ☐
Medical practitioner's / ophthalmologist's declaration:			
I, certify that I have examined the above named person, confirmed his/her identity and that I have correctly answered the questions above.			
Date of examination:		Name:	
Signature and Stamp:			

For ISSF official use only:
Investigation ☐ Rejected ☐ Approved ☐