



# Eyesight Test Form and Certificate

Applicant:											
Family Name(s)						Given Name(s)					
Date of Birth:											
	Day			Month			Year				
<b>Certifying medical practitioner / ophthalmologist:</b>											
Name, qualifications and medical specialty (for example: Dr. AB Cook, MD, General Practitioner:)											
Name				Address				Email			
Phone				Fax				Mobilephone			
1.	Is the visual acuity 0.7 (6/9 or 20/30) or better on each eye? Yes, without correction <input type="checkbox"/> Yes, but only with correction <input type="checkbox"/> Corrections:    Left: .....    Right: .....									No <input type="checkbox"/>	
2.	Is there any evidence or history of impaired night vision?									Yes <input type="checkbox"/>	No <input type="checkbox"/>
3.	Is there any defect in colour vision? If yes, what kind of defect:									Yes <input type="checkbox"/>	No <input type="checkbox"/>
4.	Is there any sign of diplopia?									Yes <input type="checkbox"/>	No <input type="checkbox"/>
5.	Are there any defects in the binocular visual field? If yes, attach vision field maps!									Yes <input type="checkbox"/>	No <input type="checkbox"/>
6.	Is there any evidence of other ophthalmic pathological conditions or diabetes? If yes, what condition(s):									Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>Medical practitioner's / ophthalmologist's declaration:</b>											
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:					
<b>National Federation's declaration:</b>											
We confirm that the applicant is fully supported by our federation to act as an international Shotgun Referee.											
Date of examination:		Name:				Signature and Stamp:					
<b>For ISSF official use only:</b>											
Investigation <input type="checkbox"/>				Rejected <input type="checkbox"/>				Approved <input type="checkbox"/>			