# Eyesight Test 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 | | Mobilephone | |

| | | |
|---|---|---|
| 1. | Is the visual acuity 0.7 (6/9 or 20/30) or better on each eye?<br>Yes, without correction ◯ Yes, but only with correction ◯<br>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: | |
|---|---|---|---|---|---|

## National Federation's declaration:

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: | |
|---|---|---|---|---|---|

## For ISSF official use only:

Investigation ☐ Rejected ☐ Approved ☐