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? 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:	

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 ☐