

**DoD Medical Examination Review Board  
8034 Edgerton Drive, Suite 132  
USAF Academy, Colorado 80840-2200**

**EYE EXAMINATION FORM**

NAME: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Applicant, please complete PART A. In accordance with the instructions provided within your remedial request letter, take this form to the eye clinic for the examination(s) requested by DoDMERB and have the optometrist/ophthalmologist complete PART B and return the completed form to DoDMERB at the above address.**

**PRIVACY ACT STATEMENT**

**AUTHORITY:** Title 10, USC 133, 3012, 5031, 8013, and Executive Order 9397

**PRINCIPAL PURPOSE:** To determine medical acceptability or update a medical file as part of the application process to a United States Service Academy, Reserve Officer Training Corp (ROTC) Scholarship Program, or the Uniformed Services University of the Health Sciences (USUHS).

**ROUTINE USES:** This information may be disclosed to the Coast Guard Academy and Merchant Marine Academy for applicants to their Academies.

**DISCLOSURE:** Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy. Use of the Social Security Number (SSN) is used for positive identification of records.

**PART A**

1) Please circle the appropriate answer about contact lenses: I DO / DO NOT wear contact lenses.

2) If applicable, the lenses I wear are (please circle the appropriate answer below about contact lenses):

SOFT / RIGID - HARD / RIGID for ortho-keratology or corneal refractive therapy

3) My contact lenses have not been worn "at all" for \_\_\_\_\_ days prior to the exam in PART B.

4) I certify the above information about my contact lens use prior to the PART B exam is true and accurate to the best of my knowledge.

\_\_\_\_\_ Applicant's Signature

\_\_\_\_\_ Date

**PART B**

**Eye Examination Data**

		17. DISTANT VISION		18. REFRACTION		MANIFEST	CYCLO	BY LENS	19. NEAR VISION	
		RIGHT 20/	CORR TO 20/	SPH	CYL	AXIS	20/	CORR TO 20/	BY	
		LEFT 20/	CORR TO 20/	SPH	CYL	AXIS	20/	CORR TO 20/	BY	
20. HETEROPHORIA/TROPIA <i>(Far only)</i>		21. COVER TEST		22. COLOR VISION				23. DEPTH PERCEPTION		
				TEST USED	RESULTS		TEST USED	SCORE		
				PIP	No. Passed	No. Failed	VTA-ND/OVT/AFVT			
				FALANT	No. Passed	No. Failed	DPA-V			
		FAIL ( <i>Tropia</i> )		OTHER ( <i>Specify</i> )		TITMUS/STEREO FLY <i>(Arcs per second)</i>				
24. NEAR POINT OF CONVERGENCE				25. VIVID RED/GREEN		26. OCULAR MOTILITY AND BINOCULARITY (RED LENS TEST)				
				PASS	FAIL	PASS	FAIL	IF FAILED:	DIPLOPIA	SUPPRESSION

If Red Lens Test (#26 above) is failed with Diplopia, please specify which position(s) of gaze: \_\_\_\_\_

For Cycloplegic Refractions only, the type of medication and regimen used: \_\_\_\_\_

\_\_\_\_\_ Doctor's Signature/Stamp

\_\_\_\_\_ Date