INTERNATIONAL BLIND GOLF ASSOCIATION SIGHT CLASSIFICATION FORM

Section 1 should be completed by the person being tested.

Section 2 is for Office use only.

Section 3 (overleaf) should be completed by an Ophthalmologist or Optometrist.

SECTION 1

NAME ______________________________________________________________________

ADDRESS ___________________________________________________________________

____________________________________________________________________________

________________________________________________ CODE_______________________

TEL   __________________________ E-MAIL  ____________________________________

DO YOU WEAR SPECTACLES OR CONTACT LENSES WHEN YOU PLAY GOLF? YES / NO

PLEASE NOTE THE USE OF VISUAL DISTANCE AIDS SUCH AS MONOCULARS IS NOT PERMITTED IN COMPETITION OR OFFICIAL PRACTICE.

THE RESULTS OF THIS TEST WILL BE HELD ON A DATABASE AND THE CATEGORY WILL BE DISPLAYED ON THE I.B.G.A. WEBSITE.

SIGNED _______________________________ DATE____________________________

SECTION 2

FOR OFFICE USE ONLY

CATEGORY  B1  B2  B3  OVER B3

NAME OF ASSESSOR (PLEASE PRINT) __________________________________________

SIGNATURE OF ASSESSOR ___________________________________________________

POSITION HELD AND DATE _________________________________________________
SECTION 3

TO BE COMPLETED BY THE OPHTHALMOLOGIST OR OPTOMETRIST.

Name of person being tested_______________________________________________________

PLEASE TEST THE VISUAL ACUITY OF THIS PERSON USING BEST SPECTACLE / CONTACT LENS CORRECTION.

TEST BINOCULAR AND BETTER EYE ACUITY BUT RECORD ONLY THE BETTER RESULT ATTAINED.

PLEASE RECORD THE RESULT ON THE HORIZONTAL SCALE BELOW. IF THE RESULT IS LESS THAN COUNT FINGERS PLEASE CHECK WHETHER HE/SHE CAN DIFFERENTIATE BETWEEN A BLANK SHEET OF WHITE PAPER AND THE SHEET OF PAPER WITH THE BLACK SYMBOL BELOW ON IT AT ANY DISTANCE OR IN ANY DIRECTION - I.E. D.S.

20/160   20/200   20/320   20/400   20/630   20/800   20/1000   CF   DS   PL   NPL

DID THE TESTEE WEAR SPECTACLES / CONTACT LENSES WHEN TESTED?

YES / NO

NAME OF OPHTHALMOLOGIST OR OPTOMETRIST

PLEASE PRINT _______________________________________________________________

SIGNATURE_______________________________________________________________

QUALIFICATION________________________________DATE______________________