Visual Acuity Form
for the European Pickleball Federation

Trainee's or Referee's Name: _____

EPF member number: _____

For Optometrist/Ophthalmologist

By signing below, I confirm that the person above meets the following visual acuity standards

	Verified
DISTANCE VISUAL ACUITY of 6/6 (meters) or 20/20 (feet), **with or without correction** (glasses/contact lenses) and **binocularly** (with both eyes open).	☐
NEAR VISUAL ACUITY of N8 or J6 at 30-45cm **with or without correction** (glasses/contact lenses) and **binocularly** (with both eyes open).	☐

Please fill out in CAPITAL LETTERS

Name of Optometrist/Ophthalmologist: _____

Registration body and number: _____

Email: _____

Location and Date: _____

Signature of Optometrist/Ophthalmologist: _____

Practice stamp with address:

For Trainee/Referee

I hereby attest to the authenticity of this form and consent to its release to any EPF officials.

Signature of trainee/referee: _____

Note: This eye test and report are valid for 3 years from the date of issuing.