DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)
CYCLOPLEGIC REFRACTION

(Please read Privacy Act Statement before completing this form.)

Form Approved
OMB No. 0704-0396
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The public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Department of Defense, Washington Headquarters Services, Directorate for Information Operations and Reports (0704-0396), 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

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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 Corps (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 applications 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.

1. NAME OF APPLICANT *(Last, First, Middle Initial)*	2. SSN OF APPLICANT	3. DATE OF EXAMINATION *(YYYYMMDD)*

4. ADDRESS OF FACILITY *(City, State, ZIP Code)*	5. TELEPHONE NUMBER OF FACILITY *(Include Area Code)*

6. CONTACT LENS DATA *(X all that apply)*

	a. I DO NOT WEAR CONTACT LENSES.
	b. SOFT CONTACT LENSES WERE REMOVED ____ DAYS PRIOR TO THE ABOVE EXAMINATION.
	c. HARD CONTACT LENSES WERE REMOVED ____ DAYS PRIOR TO THE ABOVE EXAMINATION.

d. SIGNATURE OF APPLICANT

7. FAMILY EYE HISTORY *(X all members of your immediate family who wear glasses or contact lenses.)*

	FATHER
	MOTHER
	BROTHER
	SISTER
	NONE OF MY FAMILY

8. VISION EVALUATION BEFORE INSTALLATION OF DROPS *(Before cycloplegic)*

a. DISTANT VISION		b. CURRENT RX		
OD 20/	CORR TO 20/	OD SPHERE	CYL	AXIS
OS 20/	CORR TO 20/	OS SPHERE	CYL	AXIS

c. NEAR VISION	
OD 20/	CORR TO 20/
OS 20/	CORR TO 20/

9. MEDICATION USED FOR CYCLOPLEGIC

10. VISION EVALUATION AFTER CYCLOPLEGIA OBTAINED *(NOTE: Correct to 20/20 absolute. Record number of letters missed on 20/20, i.e. 20/20-2, 20/20-3, etc. If unable to correct to 20/20, record best correctable vision. Do NOT over correct; correct ONLY to 20/20.)*

a. DISTANT VISION CORRECTED TO		b. CYCLO RX		
OD 20/	CORR TO 20/	OD SPHERE	CYL	AXIS
OS 20/	CORR TO 20/	OS SPHERE	CYL	AXIS

11. REMARKS *(Examiner should list any diagnosis which interferes with visual function which was noted on this examination.)*

12. TYPED OR PRINTED NAME OF EXAMINER	13. SIGNATURE OF EXAMINER