|  |  |
| --- | --- |
| Name of Optometrist (please print)  |  |
| Optometrist’s Business Address |  |
| Postcode |  |
| Telephone Number  |  |
| Name of employee examined  |  |
| Address of employee |  |

I am conversant with the standard recommended by the Association of Optometrists for Display Screen Equipment users and in my opinion, the above named patient:

1. Does not require visual corrective appliances specifically for VDU/DSE use Yes/No

2. Requires visual corrective appliances specifically for VDU/DSE use **\*** Yes/No

***Contribution for corrective appliances by KCC should only be made if box 2 is ticked.***

**Note: \***

Corrective appliances specifically for VDU/DSE use should only be supplied when these are necessary and when corrective appliances for any other use (such as driving, TV or reading) cannot be used. This will apply, for example, when the layout of the screen and/or documents is such that an intermediate focus is required and the user cannot see at this distance with any other corrective appliances. If you have ticked box 2 please indicate below the lens type advised and your reasons for prescribing corrective appliances specifically for VDU/DSE use.

|  |
| --- |
| **Glasses type recommended by Optometrist** |
| Single VisionBifocal |
| Progressive |
| Other (identify) |
| Reason for supply (Optometrists notes) |

|  |
| --- |
| Recommended date for next eye test |
| 1 year (delete as appropriate) Yes/No |
| 2 year (delete as appropriate) Yes/No |
| Other (Optometrist to specify if applicable) |
| Optometrists Signature |
| Date of today’s test |
| GOC Number |

This form must be passed to your manager along with receipts for eyesight examination and/or special corrective appliances where reimbursement is to be sought.