PLEASE NOTE: Managers / Authorising Officers of the employee making this claim MUST ensure that the user meets the [Display Screen User Criteria](http://intranet/our-people/hr/pay-benefits/eye-tests/) on the intranet before completing this form.

EMPLOYEE DECLARATION

|  |  |
| --- | --- |
| **EMPLOYEE NAME:** |  |
| **EMPLOYEE NO:** |  |
| **DEPARTMENT:** |  |
| **TEAM:** |  |
| **LOCATION:** |  |
| I confirm that this claim relates to an eye test and, where applicable, corrective appliances for use by me specifically for my work within this employment at Display Screen Equipment. | |
| **NOTE - You must submit this form and scan or take a photo of the receipt and email your line manager.** | |
| **DATE:** |  |

**MANAGER DECLARATION**

To be completed by **authorising Line Manager** within Department after reading [guidance notes](http://intranet/our-people/hr/pay-benefits/eye-tests/).

|  |  |  |  |
| --- | --- | --- | --- |
| I confirm that the above named employee satisfies the criteria as a display screen user and is therefore eligible to claim the costs below in relation to their sight test. | | | |
| **\*MAXIMUM CLAIM VALUE\***  Cost of sight test  **+**  **ONE** of the following:  **£40.00 -** single vision lenses  **£60.00 -** bifocals / varifocals | | *SIGHT TEST* | **\***£ |
| *FRAMES AND LENSES (if applicable)* | **\***£ |
| ***TOTAL*** | **\***£ |
| **MANAGER NAME:** |  | | |
| **JOB TITLE:** |  | | |
| **DATE:** |  | | |

**PROCESSING PAYMENTS**

To process payments, the Line Manager will need to e-mail [CRPayroll@carmarthenshire.gov.uk](mailto:CRPayroll@carmarthenshire.gov.uk) with the following information: Claimants Full Name, Employee Number, Department and amount to be reimbursed. The Line Manager should also keep a copy of this form until the next claim is made.