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 along with the optometrist’s receipt (Page 2) to your Line Manager prior to reimbursement.** | |
| **EMPLOYEE SIGNATURE:** |  |
| **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:** |  | | |
| **MANAGER SIGNATURE:** |  | | |
| **DATE:** |  | | |

**OPTOMETRIST DECLARATION**

|  |  |  |  |
| --- | --- | --- | --- |
| I confirm that the special corrective appliances prescribed are **needed specifically for work at display screens**, meet the requirements of the Health & Safety (Display Screen Equipment) Regulations 1992 and will correct vision defects at the viewing distance or distances used specifically for the display screen work concerned. | | | |
| **OPTOMETRIST NAME:** |  | **GOC NO.** |  |
| **OPTOMETRIST SIGNATURE:** |  | **DATE:** |  |
| **OPTICIAN’S STAMP OR ADDRESS:** |  | | |

**If you are unable to print this form, ask your optometrist for a letter head, signature or stamped receipt confirming that the special corrective appliances prescribed are needed specifically for work at display screens.**