

**Eye Test Form**

Please note any field with \* is mandatory

To be completed by authorised Manager

|  |  |  |  |
| --- | --- | --- | --- |
| Employee/Pay No. \* |       | Surname \* |       |
| Forename \* |       | Team/School \* |       |
| Email \* |       | Location |       |
| Tel. No.  |       | Classified as user \* | Yes [ ]  No [ ]  |
| Claimed on MyView \*  | Yes [ ]  No [ ]  |  Month Claimed \* |       |

(A ‘User’ is defined as an employee who habitually uses display screen equipment as a significant part of his/her normal work, e.g. if the individual normally uses DSE for continuous spells of an hour or more, more or less daily and whether he/she has no discretion on this matter).

Manager to approve and sign after visit to Optician.

|  |  |  |  |
| --- | --- | --- | --- |
| Manager’s signature \* |   | Date \* |       |
| Manager’s Name \* |       | Ext.  |       |

Guidance Notes

Only one claim can be reimbursed within a two year period (unless advised otherwise by the Optician).

Staff should request a form from their manager prior to visiting their optician.

The Optician should complete the reverse of the form.

The manager should then sign the form.

The maximum contribution in terms of test is £30 and glasses/contact lenses is £50.

Please note that no reimbursements will be made unless the form is accompanied by a till receipt that details the cost of the eye test and the cost of the spectacles/contact lenses separately (credit card receipts are not sufficient). All reimbursements will be made through Payroll.

Optician’s Report

I confirm that I have examined the above patient’s eyes and recommend the following\*:

|  |  |  |
| --- | --- | --- |
| * Spectacles solely for use with VDU
 |  | [ ]  |
| * Spectacles for general use including VDU work
 |  | [ ]  |
| * Contact lenses which include a middle distance prescription
 |  | [ ]  |
| * No spectacles required
 |  | [ ]  |
| * Re-examination recommended in       years

(If less than 2 yearly please state reason) |  |  |
|  Reason:       |  |  |

Invoice must indicate cost of eye test and cost of spectacles (separately)

|  |  |  |  |
| --- | --- | --- | --- |
| Cost of Eye Test\*(Test will not exceed £30) | £      |  | Optician’s Official Stamp\* |
| Cost of Spectacles/Contact Lenses\* (contribution will not exceed £50) | £      |
|  |  |
| Signed\* |       |
| Date\* |       |

Please e-mail to payroll.pensions@southampton.gov.uk

Please retain a copy for your own personal records.