# DISPLAY SCREEN USER EYESIGHT TEST REQUEST FORM

**To be completed by manager:**

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| --- | --- | --- | --- |
| **Name** |  | **Date of Birth** |  |
| **Address** |  |
| **Job title** |  | **Division** |  |
| **Authorised by:** (Line manager) |  | **Print name** |  |
| Typical working distance from eyes to screen: \_\_\_cms |

**To The Optician: -**

Please carry out a display screen user (standard) eyesight test on the person identified above as per the Health and Safety (Display Screen Equipment) Regulations 1992 as amended by the Health and Safety (Miscellaneous Amendments) Regulations 2002. Please then complete and sign the Declaration at the bottom of the page and add your Official Practice Stamp. Once completed, this form should be returned to the employee on the day of the eyesight test.

**OPTICIANS REPORT AND DECLARATION**

In accordance with the Display Screen Equipment Regulations 1992, Public Health Wales will only pay for a standard sight test and corrective appliance where the appliance is required for the use of display screen equipment. In no circumstances can the cost of the corrective appliance be applied to the purchase cost of glasses or lenses required as a result of other vision defects.

**Declaration**

I have tested the sight of the above named in accordance with the statement of good practice of the British College of Optometrists and made the following recommendation:

**[ ]  Spectacles are not required/there is no change in current prescription for DSE user**

**[ ]  Spectacles are required for general use**

**[ ]  Spectacles are required** solely for the correction of a vision defect associated with the use of display screens

**[ ]  Spectacles are required** for general use, incorporating corrective lenses for DSE use including (but not restricted to) reading, DSE work, driving etc.

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| --- |
| **Official Practice Stamp:** |

DATE OF TEST………………....…I advise a repeat sight test in....….years.

NAME OF OPTICIAN………………………………………………………………………………………

ADDRESS……………………………………………………………………………................

TELEPHONE NUMBER……………….................

SIGNED…………………………………….………..........

PRINT NAME……………..……………………….……....

|  |  |
| --- | --- |
| **Fee Summary** |  |
| Eye Examination (cost of standard test) | £ |
| Frames | £ |
| **Please select one of the following:** |
| Basic Single Vision (DSE) lenses | £ |
| Basic bifocal | £ |
| Basic varifocal | £ |
| **Total cost** | **£** |

**Please submit your claim via E-Expense and attach this form to enable reimbursement.**

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| --- |
| **Fee Summary** |
| Eye Examination | £ |
| Frames | £ |
| **Please select one of the following:** |
| Basic Single Vision (DSE) lenses (100% recoverable) | £ |
| Basic bifocal (50% recoverable – screen distance) | £ |
| Basic varifocal (33% recoverable – screen distance) | £ |
| **Total amount to be reimbursed** | **£** |