ELECTRICITY SUPPLY BOARD

V.D.U. EYE TEST REPORT FORM

NAME: _____ **STAFF NO:** _____

LOCATION: _____ AGE: _____

In line with regulations on work with display screen equipment, I have examined the abovenamed person and, having regard to the standards recommended for V.D.U. operation by the Association of Optometrists, Ireland, I find as follows:

Please Tick As Appropriate

1. Satisfies the standards without corrective lenses: ____
2. Satisfies the standards with existing corrective lenses: ____
3. Requires normal corrective lenses to satisfy the standards: ____
4. Fails to satisfy the standards: ____
5. **Requires special corrective lenses specifically to operate a Visual Display Unit** ____

COST: Eye Test:
Frames:
Lenses:
Single
Bifocal

Total: _____

REMARKS: _____

Signed: _____ Practise Name: _____

Address: _____ Date: _____

NB. CLAIMS MUST BE ACCOMPANIED BY OFFICIAL RECEIPT.

FOR OFFICIAL USE

I authorise _____ Who is a designated user under the terms of the Regulations to have eye / eyesight test.

SIGNED: _____

TITLE/POSITION: _____
(Manager must be level M or above)

DATE: _____

AMOUNT **ALLOCATION** **CERTIFIED** **PAYMENT APPROVED**