



THE HIGHLAND COUNCIL

EYE AND EYESIGHT TESTING

PART A: TO BE COMPLETED BY EMPLOYEE	
FIRST NAME:	
SURNAME:	
JOB TITLE:	
SERVICE/ LOCATION:	
HOME ADDRESS:	
PART B: TO BE COMPLETED BY LINE MANAGER	
The above employee has requested an eye/eyesight test within the provisions of the Display Screen Equipment Regulations.	
MANAGER'S SIGNATURE:	JOB TITLE:
Date:	

PART C: TO BE COMPLETED BY OPTICIAN

DATE OF EXAMINATION:

**Are corrective lenses required specifically for V.D.U work?
Yes/No**

If No, although not specifically required, would corrective lenses be of benefit for V.D.U. work along with other prescribed uses?

Yes/No

RECOMMENDED DATE FOR NEXT EXAMINATION:

SIGNED:

DATE:

OPTICIAN'S STAMP:

TO OPTICIANS:

The Highland Council will pay for:

- 1) Eyesight test - actual cost;**
- AND**
- 2) Corrective lenses/appliances - to a maximum of £75**

Please forward your bill/invoice to the appropriate employing Service of the Council. The balance to be recovered from the employee/customer at the time of the collection.

Please return this form with your invoice.

Please return this for processing to the administrative section of the employing Service.