Occupational Medicine
Environment, Health & Safety
FACILITIES PLANNING & MANAGEMENT
UNIVERSITY OF WISCONSIN–MADISON

# Prescription Safety Eyewear Application

**Employee:** I have a valid prescription and agree to wear the prescription safety glasses with side shields provided at all times when engaged in work for which they are required.

| Employee's Name (Last, First) | Employee ID (see payroll stub) | Phone |
|---|---|---|
| Job Title | Department/Academic Unit | Division/School/College |

**Employee** Signature: _____

Date: _____

**Supervisor**: A workplace hazard assessment has determined this employee performs work activities or works in an area where safety glasses are required. If prescription safety glasses will cost more than $300.00, Occupational Medicine will contact Supervisor for approval.

For billing of eyewear please provide the following:

| Department # | Program # | Fund # |
|---|---|---|

**Supervisor** Signature: _____

Printed Name: _____

Email: _____

Phone Number: _____

Date: _____

Occupational Medicine will contact the supervisor with any billing questions. It is optional to provide the name and contact of a financial specialist within the department to add a second point of contact for this information.

Name_____

Title_____

Contact_____