Prescription Safety Eyewear Application

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

All fields marked with * are required.

***Employee's Name** *(Last, First)*	***Campus ID #** *Located below name on front of Wiscard. Commonly starts with **90**.*	***Employee Phone #**
***Job Title**	***Department/Academic Unit**	***Division/School/College**

Employee: I have a valid eyeglasses prescription, and I agree to wear the prescription safety glasses with the side shields that are provided when engaged in the work duties for which they are required. I understand that the failure to present a completed form at the order appointment will result in cancellation of the appointment.

***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 the prescription safety glasses are estimated to cost more than $300.00, Occupational Medicine will contact Supervisor for approval.

For billing the cost of the eyewear, funding information must be provided in the blanks below.

Please make note of any split funding and provide separate and full funding information for each split.

***WD Cost Center** *CC followed by 6 digits* **CC _ _ _ _ _ _**	***WD Fund** *FD followed by 4 digits* ***FD _ _ _ _***	***WD Function** *FN followed by 4 digits* ***FN _ _ _ _***
***WD Driver** *2 letters (GR, GF, PJ, or PG) followed by 9 digits* Select and fill in the applicable driver work tag (*only one*):	☐ **Grant – GR _ _ _ _ _ _ _ _ _** ☐ **Gift – GF _ _ _ _ _ _ _ _ _** ☐ **Project – PJ _ _ _ _ _ _ _ _ _** ☐ **Program – PG _ _ _ _ _ _ _ _ _**	**WD Spend Category** *(default)* **SC00249**

***Supervisor** Signature: _____ *Date: _____

*Printed Name: _____

*Email: _____ *Phone Number:_____

It is optional to provide the name and contact of a financial specialist within the department to add a second point of contact regarding funding information.

Secondary Contact Name: _____ Title**:** _____ Contact: _____