**FORM DSE(SCH)3**

**RHONDDA CYNON TAF COUNTY BOROUGH COUNCIL**

**SCHEME FOR THE PAYMENT OF EYE AND EYESIGHT TEST AND PROVISION OF SPECIAL CORRECTIVE APPLIANCES IN ACCORDANCE WITH THE HEALTH AND SAFETY (DISPLAY SCREEN EQUIPMENT) REGULATIONS 1992**

**THIS FORM IS TO BE COMPLETED IN ACCORDANCE WITH THE COUNTY BOROUGH COUNCIL'S SCHEME FOR THE PROVISION OF EYE AND EYESIGHT TESTS AND PROVISION OF SPECIAL CORRECTIVE APPLIANCES (SEE DSE(SCH)2)**

**FOR COMPLETION BY THE CLAIMANT (Please use block letters)**

| PAYROLL NUMBER | PAY NUMBER | LOCATION |
|---|---|---|
| | | |

SURNAME _____

FORENAME(S): _____

ADDRESS:

_____

POST CODE: _____

GROUP IN WHICH EMPLOYED: _____

DATE OF EYE AND EYESIGHT TEST: _____

NAME OF OPTICIAN VISITED: _____

ADDRESS OF OPTICIAN VISITED: _____

1. EYE AND EYESIGHT TEST: £ _____

2. PROVISION OF 'SPECIAL' CORRECTIVE APPLIANCES

BASIC FRAME SINGLE VISION LENSES: £ _____

**THE AMOUNT BEING CLAIMED MUST NOT EXCEED THE MAXIMUM SET OUT IN THIS SCHEME (SEE DSE (SCH) 2)**

TOTAL COST _____

I CERTIFY THAT THIS CLAIM IS CORRECT, AND IN ACCORDANCE WITH THE SCHEME FOR THE PROVISION OF EYE AND EYESIGHT TESTS, AND THAT I HAVE ACTUALLY ATTENDED THE OPTICIAN INDICATED FOR AN EYE AND /EYESIGHT TEST. I CERTIFY THAT I HAVE INCURRED THE EXPENDITURE AS DETAILED ABOVE.

SIGNED: _____ DATE: _____

CLAIMANT

I CERTIFY THAT THIS CLAIM IS CORRECT AND IN ACCORDANCE WITH THE SCHEME FOR THE PROVISION OF EYE AND EYESIGHT TESTS AND THAT THE TEST WAS NECESSARY.

SIGNED: _____ DATE: _____

AUTHORISING OFFICER

**NOTE: ALL RECEIPTS MUST BE ATTACHED**