**FORM DSE (SCH) 1**

**FOR COMPLETION BY OPTICIAN – EYE AND EYESIGHT TEST REPORT**

**NAME OF OPTICIAN:**

**ADDRESS:**

**POST CODE:**

**TO: RHONDDA CYNON TAF COUNCIL**

**RE:**       **(‘USER’ NAME)**

I am conversant with the standard recommended by the Association of Optometrists for Display Screen Equipment users and, in my opinion, the above-named ‘user’ (please tick appropriate following box):

1. Requires no prescription [ ]
2. Requires a prescription specifically for DSE use only [ ]
(i.e. special corrective appliances)
3. Requires a prescription for general use (which may include DSE use) [ ]

# COSTS

Eye Examination: £

Special Corrective Appliances: £

Total: £

Any additional comments (including date of repeat testing):

Signed:       Optician

Date:

# FORM DSE (SCH) 2

**INFORMATION FOR USERS**

Arrangements have been made with the opticians listed below to provide eye and eyesight test and, where necessary, ‘special corrective appliances’ to those employees who have been designated as ‘users’ of display screen equipment. A user who wishes to make their own arrangements with an optician of their choice may do so providing any claim does not exceed the maximum amount set out under this scheme as detailed below:

# SPECSAVERS OPTICIANS

Branches:

|  |  |
| --- | --- |
| 20b Victoria SquareAberdare | 65/66 Taff StreetPontypridd |
| Tel. No. 01685 875050 | Tel. No. 01443 480244 |

# A B OPTICIANS

Branches:

13 Commercial Street Aberdare

Tel. No. 01685 870007

# COSTS TO BE RECLAIMED BY THE 'USER'

1. Eye and Eyesight Test - up to a maximum of £15.00.
2. Provision of Special Corrective Appliances - up to a maximum of £49.95

Any additional other costs which exceed the above must be paid for by the user.

The Council's scheme requires the user to pay the optician direct and reclaim costs as expenses on Form DSE (SCH) 3.

# FORM DSE (SCH) 3

**FOR COMPLETION BY USER AND AUTHORISATION BY LINE MANAGER** (apart

from signatures, 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: £

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

1. 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**

**SCHEME HS 11A**

# MANAGERS CHECKLIST

|  |  |
| --- | --- |
|  | ✓ As appropriate |
| N/A | Yes | No |
| * Has a copy of Policy HS11 and this Scheme HS 11A been brought to the notice of all employees who have been designated as DSE users?
 | [ ]  | [ ]  | [ ]  |
| * Are there procedures in place to ensure that DSE users receive all costs authorised under the scheme promptly?
 | [ ]  | [ ]  | [ ]  |
| * Are records being kept of all user employees who have had eye and eyesight tests and, where applicable, been provided with special corrective appliances (spectacles)?
 | [ ]  | [ ]  | [ ]  |
| * Are there monitoring procedures in place to ensure that the provisions of the scheme are being followed?
 | [ ]  | [ ]  | [ ]  |

Completed by:       Confirmed by:

(Signature) (Signature

Name:       Name:

(Print) (Print)

Designation:       Designation:

Date:       Date: