

 DSE User Eye Test Authorisation form

1. **Employee/Person authorising to complete**

|  |  |
| --- | --- |
| **Employee name** |  |
| **School/Service** |  |
| **Employee Signature** |  |
| **Date** |  |

1. **Authorisation (Line Manager, DSE Assessor or SSA)**

|  |  |
| --- | --- |
| **Authorisation signature** |  |
| **Print name** |  |
| **Date** |  |

1. **Optician to complete**

|  |  |
| --- | --- |
|  | **Please tick one** |
| Spectacles have **not** been prescribed |  |
| Spectacles are prescribed solely for DSE use |  |
| Spectacles are prescribed, but are **not** specifically for DSE use |  |

|  |  |
| --- | --- |
| Recommended re-test date |  |
| Other comments (e.g. recommend Occupational Health referral) |  |
| **Optician signature** |  |
| **Print name** |  |
| **Date** |  |
| **Optician address** |  |