MANITOBA ASSOCIATION OF OPTOMETRISTS

Occupational Vision Care Plan
Authorization Form – CLIENT COMPANY

This form must be signed and presented at an OVC Participating Practice

When making your appointment, please inform the Optometrist's office that you are part of the OVC program

V.001

FAX FORM TO: 1-888-376-0111

EMPLOYER

Employer Name: **Red River College (Employee)**

Location:_____

Supervisor Name:_____

Supervisor Ph.:_____

Supervisor Signature:_____

EMPLOYEE

Employee Name:_____

Employee Number:_____

Employee Ph.:_____

Department:_____

Coverage Details

Employer pays for safety eyewear to a **maximum of $160, amounts over $160 must be paid by Employee at dispensary. Ultraguard scratch coating is mandatory.** Employee may claim from existing insurance benefits if applicable.

☐ Total eyewear cost exceeds Employer max of $160. Employee paid at dispensary for the following amount: $_____

OPTOMETRIST

Practice Name/Location (or stamp):_____

_____

_____

Contact:_____

EYE EXAM

Examining Optometrist:_____

Date of Exam:_____

Exam Fee: *Employee pays*

SAFETY EYEWEAR

**recommended*

Lens Specifications

	Lens Type (ex. Jena 4K, FT28, etc.)	*Material*	*SEG Height*	*OC Height*	*Coating Type*	*Sun Protection*
☐ SV ☐ BF ☐ PAL ☐ Other:_____		☐ Trivex* ☐ Plastic (CR39) ☐ Polycarbonate			☒ Ultraguard ☐ LuxAR ☐ LuxAR U ☐ Clear Blue ☐ UV 400	☐ Tint, Colour:_____ (up to 30% density allowed as per CSA) ☐ Transitions Brown or Grey (circle one) ☐ Neochrome Grey ☐ Polarized

Lens Prescription

Rx	*SPHERE*	*CYL*	*AXIS*	*PRISM*	*ADD*	*PD*
Right (OD)						
Left (OS)						

Frame Specifications

Model #:	*Eye Size*	*Bridge Size*	*Temple Size*	*Colour*	*Side Shields*
					☒ Permanent (mandatory)

EMPLOYEE MUST SIGN BELOW:

I understand the OVC program will use the information contained on this form only for the purpose of fulfilling its obligation to my employer. All or some of the information contained on this form may be released to my employer, the providing optometrist, and to the OVC lab and administrator.

Signature:_____

I acknowledge receipt of safety eyewear ordered. I understand the procedures for the proper care of safety eyewear. I also understand that no safety lenses are absolutely unbreakable or shatterproof.

Signature:_____

CERTIFICATIONS

Optical Laboratory Certification

Lab Invoice #:_____

Date Completed:_____

Dispensing Certification

Safety Glasses Dispensed are as Ordered:

Optometrist Signature:_____

Date:_____

Use of materials outside CSA standards requires explicit written consent of employer and employee.