

**NATURAL RESOURCES SERVICE CENTER  
VIDEO DISPLAY TERMINAL OPERATOR EYE EXAM/LENS PAYMENT**

**NOTE: For reimbursement, four items are required:**

- 1) Employee completes section "A" for supervisor's approval.
- 2) Supervisor approves form and completes Exam/Lenses payment codes in section "B"
- 3) Employee attaches original bill(s) and receipts, and completes Section "C"
- 4) Attach Page 2 (Certificate Authorizing Release of Information completed by employee, and Eye Exam Report completed by doctor).
- 5) Employee has waited one year from date of last annual exam.

**Forward documents to:** Natural Resources Service Center, Human Resources, 155 State House Station, Augusta, ME 04333-0155.

**A. Employee Name (Please Print):**

Job Title \_\_\_\_\_ Agency \_\_\_\_\_

Mailing Address: \_\_\_\_\_

I request that my annual eye exam be paid by the State as I spend at least 80% of my time operating a Video Display Terminal.

Employee Signature: \_\_\_\_\_ Date \_\_\_\_\_

**B. Supervisor completes this section:**

*The immediate supervisor confirms that this employee spends at least 80% of their time operating VDT's in accordance with the Video Display Terminal Operators' Article of the applicable collective bargaining agreement between the State of Maine and MSEA.*

**Supervisor Approval** \_\_\_\_\_ **Date** \_\_\_\_\_ **Print Name** \_\_\_\_\_

**Required Codes for processing payment:**

	Fund	Agency	Report Org	App Unit	C&O	(Optional) Rep Cat	(Optional) Project
Exam	_____	_____	_____	_____	4880	_____	_____
Lenses	_____	_____	_____	_____	4881	_____	_____

**C. Employee completes this section:**

**REIMBURSEMENT**

**Reimburse to:**  
**Employee    Vendor**

• **Exam:** Insurance Exam Co-Pay: \$ \_\_\_\_\_ (\$15) → ( ) ( )  
or Full Exam Fee for VDT \$ \_\_\_\_\_ → ( ) ( )  
purposes

• **Lenses:** (Single Rx) \$ \_\_\_\_\_ (\$75 Max) → ( ) ( )  
(Administrative Services Bargaining Unit Only) \$ \_\_\_\_\_ (\$100 Max) → ( ) ( )

(Bifocal, Trifocal or Progressive) \$ \_\_\_\_\_ (\$125 Max) → ( ) ( )  
(Administrative Services Bargaining Unit Only) \$ \_\_\_\_\_ (\$150 Max) → ( ) ( )

Enter Total Reimbursement to Employee \$ \_\_\_\_\_ and/or Total Reimbursement to Vendor \$ \_\_\_\_\_

If reimbursing to Vendor: Vendor Name & Address: \_\_\_\_\_  
Vendor ID# \_\_\_\_\_

VERIFICATION: Natural Resources Human Resources Staff:

\_\_\_\_\_  
Signature  
revised 7/07

\_\_\_\_\_  
Print Name  
- 1 of 2 -

\_\_\_\_\_  
Date

**CERTIFICATE AUTHORIZING RELEASE OF INFORMATION**

(To be completed by Employee)

TO \_\_\_\_\_  
(Name of Eye Care Provider/Physician)

Telephone No. \_\_\_\_\_

\_\_\_\_\_  
Address

EMPLOYEE \_\_\_\_\_

ADDRESS \_\_\_\_\_

\_\_\_\_\_

AGENCY/DEPT \_\_\_\_\_

ADDRESS \_\_\_\_\_

I, \_\_\_\_\_ hereby authorize the above-mentioned agency/department and its duly  
(Name of Employee)  
appointed representative \_\_\_\_\_

(Natural Resources Service Center Human Resources Staff)

To obtain, examine, copy or reproduce in any manner, any and all information, records, documents, or reports in your possession relating to this eye exam.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Witness

**STATE OF MAINE  
VIDEO DISPLAY TERMINAL OPERATOR  
EYE CARE PROVIDER STATEMENT/EYE EXAM REPORT  
(To be completed by Examining Provider)**

EMPLOYEE NAME \_\_\_\_\_ DEPARTMENT \_\_\_\_\_

I have examined the above named individual and recommend that:

The individual should have: single vision lenses \_\_\_\_\_

bifocal/trifocal/progressive lenses: \_\_\_\_\_

Date of This Examination \_\_\_\_\_

\_\_\_\_\_  
Examiner's Name (Please print)

Date of Previous Examination \_\_\_\_\_

\_\_\_\_\_  
Examiner's Signature