NATURAL RESOURCES SERVICE CENTER
VIDEO DISPLAY TERMINAL (VDT) OPERATOR EYE EXAM/LENS PAYMENT

NOTE: For reimbursement, five items are required:

1) Employee has waited one year from date of last annual exam.
2) *Section "A":* Employee completes for supervisor's approval.
3) *Section "B":* Supervisor and Authorized Agency Official approves form and completes Exam/Lenses payment codes.
4) *Section "C"*: Employee completes appropriate sections and attaches original bill(s) and receipts.
5) *Page 2*: (Certificate Authorizing Release of Information) Employee completes top and Eye Exam Report completed by doctor.

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. *Agency Approval 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: _____ ***Date***_____ ***Print Name***_____

Authorized Agency Official: _____ ***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:**	
Exam:			**Employee**	**Vendor**
or	Insurance Exam Co-Pay:	$ _____ ($25)	( )	( )
	Full Exam Fee for VDT purposes	$ _____	( )	( )
Lenses:	(Single Rx)	$ _____ ($100 Max)	( )	( )
	(Bifocal, Trifocal or Progressive)	$ _____ ($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 Service Center Human Resources Staff member:

_____ _____ _____

Human Resource Signature **Print Name and Title** **Date**

CERTIFICATE AUTHORIZING RELEASE OF INFORMATION

(To be completed by Employee)

TO _____ **Telephone No.** _____

(Name of Eye Care Provider/Physician)

_____

Address

EMPLOYEE _____

ADDRESS _____

_____

AGENCY/DEPT _____

ADDRESS _____

I, _____hereby authorize the above-mentioned agency/department and it's 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