UPDATED 2/8/2012

CITY OF OAKLAND
VDT GLASSES AUTHORIZATION REQUEST FORM (AI 2901)

SECTION1: EMPLOYEE INFORMATION

EMPLOYEE NAME: _____ EMPLOYEE NUMBER: _____

JOB CLASSIFICATION: _____ BARGAINING UNIT: _____

AGENCY/DEPARTMENT: _____

ADDRESS: _____

PHONE: EMAIL:

AI 2901

Supervisor:_____, I here by certify that the named employee above is exposed to more than 18.75 hours per work week and has obtained a prescription from their personal eye specialist/doctor at their own expense or through their City paid Vision Benefit. Supervisors Signature:_____

BRIEFLY DESCRIBE YOUR VDT USE PATTERNS:

HAVE YOU ATTENDED THE REQUIRED ERGONOMICS TRAINING COURSE _____

HOW MANY HOURS PER DAY DO YOU OPERATE A VDT? _____

HAS YOUR PERSONAL EYE DOCTOR PRESCRIBED VDT GLASSES? _____ (PLEASE ATTACH COPY OF PRESCRIPTION TO THIS FORM.)

SECTION 3 :AUTHORIZATION TO RECEIVE BENEFIT *(To be completed by Risk Management)*

_____ Prescription Attached _____ Bargaining Unit Eligible _____ Exposure Criteria Met

_____ Approved _____ Not Approved (state reason: _____)

The above cited employee is hereby authorized/not authorized to participate in the City's VDT Glasses Program and is eligible to receive one pair of VDT glasses. (Strike non-applicable language)

_____ _____

Risk Management, Authorizing Signature Date

INSTRUCTIONS

1. Employee completes section 1 and 2 above.
2. Attach copy of prescription form from personal eye doctor recommending the use of VDT glasses
3. Mail or fax completed form and prescription to:

City of Oakland,
Risk Management Division
150 Frank H. Ogawa Plaza, Suite 2352
Oakland, CA 94612
(510)238-7971/(510)238-4749(Fax)