

Eye Test Policy for Users of Display Screen Equipment

1. Purpose

This policy outlines the arrangements for eye and eyesight testing at Monitor.

2. Scope

This policy covers all staff who work under a contract of employment on a permanent or fixed-term appointment with Monitor and who habitually use display screen equipment as a significant part of normal work (for continuous spells of an hour or more at a time).

3. Policy Statement

You are entitled to request an appropriate eye or eyesight test to be carried out by a competent person. You may request a test at regular intervals (two years or longer).

You are also entitled to special corrective appliances appropriate for the work required by your role, where:

- normal corrective appliances cannot be used; and
- the result of any eye and eyesight test, which the user has been given in accordance with this policy, shows such equipment to be necessary.

The cost of the test plus a contribution towards special corrective appliances, **if needed for VDU-use only**, will be met by Monitor; up to £30 for the test and up to £60 contribution for special appliances.

If you think you are eligible (in terms of the above), and wish to have an eyesight test please complete the attached form and have it countersigned by Human Resources.

Please also ask your optician to complete the form '*Result of VDU Eyesight Examination*' (below).

All information provided by the optician will be held on your personal file.

This policy has been in operation since August 2004 and was updated in August 2005, September 2006 and September 2008.

STAFF REQUEST FOR VDU EYESIGHT EXAMINATION

Name (please print):

Directorate:

I consider that I habitually use display screen equipment as a significant part of normal work (for continuous periods of an hour or more at a time) and request an eyesight test to be carried out by an optician.

I normally wear spectacles or contact lenses for reading or general use **Yes/No**
(Delete as appropriate)

Date of last eyesight test:

Number of days you work each week:
.....

Hours per day spent on VDU work:

Signed: Date:

Countersigned: Job Title:
(by Human Resources)

Date:

PLEASE ENSURE THE OPTICIAN COMPLETES EYE FORM 2.

EYE FORM 1

RESULT OF VDU EYESIGHT EXAMINATION

SURNAME	FIRST NAMES	TITLE
DATE OF BIRTH	DIRECTORATE	DATE OF EXAMINATION

DECLARATION TO BE SIGNED IN ALL CASES

I am fully conversant with the standard recommended by the Association of Optical Practitioners for VDU Operators

In my opinion the above named individual:-
(Please tick one as appropriate)

1 Satisfies the standard without spectacles or with existing spectacles

2 Fails to satisfy the standard and requires spectacles to correct a refractive error **but not solely for VDU use**

3 Fails to satisfy the standard and requires spectacles or a modification to an existing appliance **solely for VDU use**

I recommend re-examination in.....year(s).

Additional comments (if appropriate)

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.....

.....

Signed.....

Name/Qualifications.....

TO BE COMPLETED BY THE MEMBER OF STAFF FOLLOWING THE EYE TEST:

I am/ am not claiming any costs as a result of this visit

Costs claimed: EYE TEST AMOUNT CLAIMED £.....

CONTRIBUTION TO SPECTACLES

AMOUNT CLAIMED £.....

RECEIPT ATTACHED

Signed.....

Date.....

Please return a copy of this form to HR and then take the original to Finance for reimbursement.