State Vision Plan

Prescription Safety Glasses Certification Form

This form must be downloaded and completed in either Adobe Reader or Adobe Acrobat DC. The submit button will not function if opened in a web browser.

THIS FORM IS ONLY TO BE COMPLETED BY HR OFFICES on behalf of employees requesting prescription safety glasses

Has the employee already purchased the prescription safety glasses?

YES: Do not complete this form. Prescription safety glasses purchased prior to approval are not eligible for reimbursement.

NO: Please complete the entire form as instructed.

Section 1: Information about the employee seeking prescription safety glasses. The Work Email field should be completed in order for the employee to receive confirmation of approval.

Employee First Name: **Employee Last Name:**

Employee ID: **Date of Birth:** **Gender:**

Phone #: **Work Email:**

Section 2: To be completed by the HR Office. A copy of this form is not forwarded to the employee so HR information on this form is not disclosed.

HR Approval: I confirm that the employee listed above is eligible to receive:

HR Rep:

HR Rep Employee ID:

HR Rep Phone #:

HR Email:

HR eSignature:

This form should only be submitted by HR Offices.

Prescription Safety Glasses
(Group ID 1017762/Subgroup 1001)

SUBMIT