

**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:

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

C. Employee completes this section:

REIMBURSEMENT

Reimburse to:
Employee Vendor

- **Exam:** Insurance Exam Co-Pay: \$ _____ (\$25) → () ()
or Full Exam Fee for VDT purposes \$ _____ → () ()
- **Lenses:** (Single Rx) \$ _____ (\$75 Max) → () ()
(Administrative/Supervisory/Confidential Only) \$ _____ (\$100 Max) → () ()

(Bifocal, Trifocal or Progressive) \$ _____ (\$125 Max) → () ()
(Administrative/Supervisory/Confidential 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

Print Name and Title

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