Fortney Eyecare Associates

PRESCRIPTION SAFETY EYEWEAR AUTHORIZATION

PART 1 - TO BE COMPLETED BY SAFETY SUPERVISOR

1. Employee Name (First, Middle, Last)	2. Employee Social Security #:	3. Date of Birth:	4. Sex:
5. Employee's Street Address:	6. City, State, Zip:		
7. Employee's Telephone:	8. Company:		

This is an authorization for one pair of safety glasses for the above employee. This authorization is good for 90 days from issuance.

Signature: Date:

PART 2 - TO BE COMPLETED BY DOCTOR

Rx	SPHERE	CYLINDER	AXIS	ADD	SEG HEIGHT	BASE CURVE	PRISM	PD FAR / NEAR
O.D.								/
O.S.								/

FRAME MANUFACTURER: ___ TITMUS ___ ADEN	FRAME MODEL:	EYE SIZE/BRIDGE/TEMPLE: / /
FRAME COLOR:	ORDER TYPE: ___ FRAME & LENS ___ FRAME ONLY ___ LENS ONLY	LENS STYLE: ___ SINGLE VISION ___ BIFOCAL ___ TRIFOCAL ___ PROGRESSIVE
SIDESHIELDS: ___ DETACHABLE ___ PERMANENT	LENS MATERIAL: ___ PLASTIC ___ POLYCARBONATE ___ GLASS	LENS THICKNESS: INDUSTRIAL
TINT: ___ ROSE 10 ___ ROSE 20 ___ BROWN 10 ___ WELDERS GREEN	OTHER: UV: ___ SCT: ___	
DR. NAME:	DR. ADDRESS:	DR. PHONE #:
SPECIAL INSTRUCTIONS:		

PART 3 - TO BE COMPLETED BY FORTNEY EYECARE

SEND COMPLETED JOB TO:

TOTAL CHARGE: _____ PLANT BALANCE: _____ EMPLOYEE BALANCE: _____

FILL IN ORDER FORM AND MAIL TO OR FAX TO FORTNEY EYECARE AT (810) 751-4111