

# EMPLOYEE APPLICATION FOR PROTECTIVE EYEWEAR

## EMPLOYEE INFORMATION:

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Dept: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Describe the duties you perform which expose you to eye hazards:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are prescription lenses needed? \_\_\_\_\_

Employee's department will be billed for required safety eye protection.

### SUPERVISOR APPROVAL

Signature: \_\_\_\_\_ Phone Number \_\_\_\_\_

Account Code to be billed to: \_\_\_\_\_

Fiscal Person: \_\_\_\_\_ Phone Number: \_\_\_\_\_