WorkSafe
WORKERS' COMPENSATION BOARD OF BC
PO Box 4700 Stn Terminal, Vancouver BC V6B 1J1
Fax 604 233-9777
Toll Free Fax 1 888 922-8807

FORWARDING FORM REGARDING EYEGLASSES

Worker and Employer Services Division

This Form Is Not Accepted As An Account

Worker's name	Claim number

Worker's personal health number from BC CareCard

The information required is that referable to the damage done in the accident. The Board does not assume responsibility for any other services rendered.

This worker has requested that the WCB consider replacement of or repair of eyeglasses/contact lenses which were damaged while at work.

It would be appreciated if you would answer the following questions and return this form to the WCB office, so that we may assess the amount payable for the actual damage sustained.

1.	Please check (✔) one box only: a) ❒ Single vision lens b) ❒ Round top bifocal	c) ❒ Flat top bifocal d) ❒ Trifocal	e) ❒ Contact lenses	
2.	Please state sphere, cylinders Please give full details	O.D. add. O.S. add.	Circle division 1st or 2nd	
3.	Please check if supplied	❒ Tint	❒ Prism	❒ Hardex
4.	Frames: Please describe types supplied			
5.	Who supplied the previous glasses?			
6.	When were they supplied?			
7.	Are the new glasses the same quality of frame?		❒ Yes	❒ No
8.	Are the new glasses the same lens type and quality as the old ones?		❒ Yes	❒ No

Signature of physician-optician, optometrist, or optician	Date *YY / MM / DD*