OPTICAL AIDS SUBSIDY FORM

Please print and complete the form below. Scan the completed form along with the supporting documents in order to submit your claim to ESB.admin@education.wa.edu.au or post to Employee Support Bureau, 151 Royal St. East Perth 6004.

- Receipts from the purchase of corrective optical aids
- Statement of reimbursement from Private Health Fund

PERSONAL INFORMATION (staff member to complete)

Surname_____ First name_____ ID number_____

Address_____ Postcode_____

Date of birth ____/___/____ Job title_____

School/ worksite _____

Type of computer used	Laptop/notebook/tablet	☐	Desktop	☐
Frequency of use:	1-5 hours per day	☐	5+ hours per day	☐

PAYMENT DETAILS

Direct Electronic Funds Transfer:

Account Name: _____

Bank _____ Branch: _____

BSB Number: __ __ __ __ __ __ __ __Account Number: __ __ __ __ __ __ __ __ __

ELIGIBILITY AUTHORISATION (line manager/ principal to complete)

The above named staff member currently uses a computer for at least one hour continuously each working day or at least 10 hours in a working week. They are also a permanent employee or a fixed term employee who has been employed for at least 12 months continuous service.

Signed_____Position_____

School/ directorate _____ Contact number _____

OPTOMETRIST CERTIFICATION

This is to certify that the above named person requires optical aids when using a computer.

If more than one pair of glasses has been purchased, please only show costs for the pair of glasses required for computer use.

Cost of Frames and Lenses $_____

Less Medical Benefit $ _____ (for pair of glasses being claimed)

TOTAL PAID IN FULL $ _____

Signature of optometrist: _____ Date: _____

Name of company: _____