JMU Facilities Management

Prescription Safety Glasses Approval Form

Employee Name: _____ Date: _____

Department: _____ Shop: _____

1. Initial Purchase

Check One:
☐ New Hire
☐ Job Reassignment
☐ Existing Position

If you are a new hire or have been reassigned to a new position, please explain the work activities you will be performing that require you to wear safety glasses.

_____

_____

_____

2. Replacement

Check One:
☐ Lost
☐ Damaged

If you require a replacement for lost or damaged safety glasses, please explain the circumstances surrounding the loss or damage of the glasses. Also, include the damaged safety glasses with the form.

_____

_____

_____

I attest that all of the statements are true to the best of my ability and knowledge.

Employee Signature: _____ Date: _____

☐ Approve ☐ Deny (check one)

Supervisor's Signature: _____ Date: _____

☐ Approve ☐ Deny (check one)

Director's Signature: _____ Date: _____