Safety Requirements Questionnaire

Please complete the entire form and bring it with you on your first safety eye care visit.

vsp vision care

Name _____ Client Number _____

Employer _____ Job Description _____

Work/Tasks

Typical Work Tasks	Average Time Viewing	Distance
_____	_____ hours	_____ inches
_____	_____ hours	_____ inches
_____	_____ hours	_____ inches
_____	_____ hours	_____ inches
_____	_____ hours	_____ inches

Work is performed ❑ High ❑ Low ❑ Air Conditioning

Work is performed while ❑ Sitting ❑ Standing ❑ Walking ❑ Driving

ANSI Standards now include two levels of protection: Basic Impact and High Impact. It is your employer's responsibility to assess your work facility and determine the level of protection you require.

Level of protection ❑ Basic Impact ❑ High Impact

Work Environment

Humidity

❑ Indoors ❑ Outdoors ❑ Air Conditioned

Lighting

❑ Bright ❑ Dark ❑ Average ❑ Natural
❑ Fluorescent ❑ Incandescent

Lighting

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❑ Fluorescent ❑ Incandescent

Are any of the following present?

❑ Infrared ❑ Ultraviolet ❑ Glare ❑ Radiation
❑ Fluorescent ❑ Incandescent

Temperature

❑ Hot ❑ Cold ❑ Average

Do you work with moving machinery?

❑ Yes ❑ No

If yes, are any of the following present?

(Check all that apply)
❑ Metal Particles ❑ Non-Metal Particles ❑ Dust

Do you work with chemicals?

❑ Yes ❑ No

If yes, are any of the following possible?

(Check all that apply)
❑ Chemical Fumes ❑ Chemical Splash?

Personal Information

Do you wear contact lenses?

❑ Yes ❑ No

Do you have special vision requirements?

❑ Yes ❑ No