SAFETY REQUIREMENTS QUESTIONNAIRE

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

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

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

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