

*This form must be signed and presented at an OVC Participating Practice
When making your appointment, please inform the Optometrist's office that you are part of the OVC program*

V.001

FAX FORM TO: 1-888-376-0111

Member must show valid College of Physiotherapists of Manitoba Registration Certificate

Sample:



College of Physiotherapists of Manitoba (CPM)

MEMBER INFO (to be completed by OD office when ID is shown)

Member Name: _____

Registration No.: _____

Member Ph.: _____

OPTOMETRIST

Practice Name/Location (or stamp): _____

Contact: _____

EYE EXAM

Examining Optometrist: _____

Date of Exam: _____ Exam Fee: *Member pays*

Coverage Details

CPM Members pay all costs at dispensary and may claim from insurance coverage, if any.

SAFETY EYEWEAR

Lens Specifications

	Lens Type	Material	SEG Height	OC Height	Coating Type	Sun Protection
<input type="checkbox"/> SV <input type="checkbox"/> BF <input type="checkbox"/> PAL <input type="checkbox"/> Other: _____	(ex. Jena 4K, FT28, etc.)	<input type="checkbox"/> Trivex <input type="checkbox"/> Plastic (CR39) <input type="checkbox"/> Polycarbonate			<input type="checkbox"/> Ultraguard & Zero-Fog <input type="checkbox"/> LuxAR & Zero-Fog <input type="checkbox"/> LuxAR U <input type="checkbox"/> Zero-Fog Mask <input type="checkbox"/> Clear Blue <input type="checkbox"/> UV 400	<input type="checkbox"/> Tint, Colour: _____ (up to 30% density allowed as per CSA) <input type="checkbox"/> Transitions Brown or Grey (circle one) <input type="checkbox"/> Neochrome Brown or Grey (circle one) <input type="checkbox"/> Polarized

Lens Prescription

Rx	SPHERE	CYL	AXIS	PRISM	ADD	PD
Right (OD)						
Left (OS)						

Frame Specifications

Model #:	Eye Size	Bridge Size	Temple Size	Colour	Side Shields
					<input checked="" type="checkbox"/> Permanent (mandatory)

CPM MEMBER MUST SIGN BELOW:

I understand the OVC program will use the information contained on this form only for the purpose of fulfilling its obligation to CPM. All or some of the information contained on this form may be released to CPM, the providing optometrist, and to the OVC lab and administrator.

Signature: _____

I acknowledge receipt of safety eyewear ordered. I understand the procedures for the proper care of safety eyewear. I also understand that no safety lenses are absolutely unbreakable or shatterproof.

Signature: _____

CERTIFICATIONS

Optical Laboratory Certification

Lab Invoice #: _____

Date Completed: _____

Dispensing Certification

Safety Glasses Dispensed are as Ordered:

Optometrist Signature: _____

Date: _____

Use of materials outside CSA standards requires explicit written consent of CPM Member and employer.