



EYE EXAM REIMBURSEMENT FORM

Applicable to UNIFOR 2458 Full Time Group ONLY

For the refund of eye exam costs once each calendar year, to those CAW employees who spend the majority of their time operating VDT's.

Last Name: _____

First Name: _____

Middle Name: _____

Employee I.D.: _____

Faculty/Department/Business Unit: _____

Amount Refunded: _____

This reimbursement will be charged to the same business unit as your payroll and to object account .8295.14

DEPARTMENTAL AUTHORIZATION:

Name (please print)

Signature

PLEASE ATTACH ORIGINAL RECEIPT ONLY FOR REIMBURSEMENT AND FORWARD TO PAYROLL

Submit Form To: Payroll Department. Any inquiries should be directed to this department at (519) 253-3000 ext. 2135