Ref. No.

To : Safety and Health Unit (FMO)
(Fax: 3442 0505)

REQUEST FOR EYESIGHT TEST

Requesting Department / Centre: _____
Remark: Initial requested by _____ (Email: _____)
Supervisor: _____

Staff's/student's Full Name (Prof/Dr/Mr/Mrs/Ms)	CityU ID Number	Phone Number	Email

Total number of staffs : _____
Requested by MSE technical office : _____
Email: _____
:
Signature _____

Approved by Head/
Associate Head of Department : _____

Signature : _____

Date : _____