

STATE OF NEW YORK – DEPARTMENT OF CORRECTIONS AND COMMUNITY SUPERVISION
CORCRAFT/DOCCS EYEWEAR

TO: WALLKILL OPTIC LAB

FROM: _____
 Correctional Facility

SUBJECT: SAFETY GLASSES

DATE: _____

 Facility Contact Staff and Telephone Number _____ Ext.

Employee's Item Number: _____

D I S T A N C E		SPHERE	CYL	AXIS	AXIS	PRISM	DEC
	O D						
	O S						
A D D			BIFOCAL	SEGMENT WIDTH	SEGMENT WIDTH	INSET	TOTAL INSET
				P D	P D	FAR	NEAR

Frames: _____

PO #: _____

 Employee Signature (required when issued)

Date Issued: _____

File: Employee Personal Medical File