EST. 1961

PEARLE VISION™

SIGHT PASS

Date: ______________________________

Name of Patient: ___________________________ **Date of Birth:** _____________ **Age:** ________

Address: _______________________________ **City:** ______________________ **Zip:** ____________

Home #: _________________________________ **Cell #:** ____________________________________

Please indicate below, the **SIGHT PASS** services that your club will provide

SINGLE VISION: Flat-Top 28 in Basic CR-39

______ Our club will pay **$100.00**

PROGRESSIVE: Single vision Transition, Thin Lens

______Our club will pay **$125.00**

PROGRESSIVE: Transition, Thin Lens

______Our club will pay **$150.00**

Please include the Payment for the full amount or this request will not be processed.

Amount due for this

Referral$______________

FRAME ALLOWANCE: There will be a maximum of a $129.00 Frame allowance.

OTHER OPTIONS: Any other options requested by the client will be the responsibility of the client, unless a prior arrangement for funding has been agreed upon with the Lions Club.
Pearle Vision will offer a 20% discount on other options.

Please indicate
PEARLE VISION CLINIC LOCATION: ____

Club Name: ____ District________________________

Club Representative: ____________________________________ E-mail: ______________________________

Address: _______________________________ City: ________________________ Zip____________________

Home #: ____________________________ Cell # ______________________ Work # ______________________

10-17-2017