"SIGHT PASS"
CLUB APPROVAL FORM

Make Check Payable to LIF and Return Approval Form To:
Lions of Illinois Foundation
700 N Peace Road, Suite B, DeKalb, IL 60115

Date: _____

Name of Client: _____ **Date of Birth:** _____ **Age:**_____

Address: _____ **City:**_____ **Zip:**_____

email: _____ **Cell:**_____

Please Indicate Below the Services that your Club will Provide

☐	**Full Comprehensive Eye Exam**	**$50.00**
☐	**Single Vision Spectacle Lenses**	**$150.00**
☐	**IF Needed, Our club will Pay for Bifocal lenses** *(Please Invoice Our Club for additional cost if needed)*	**$50**

Contact Lenses are Not covered by the "Sight Pass" Program

Please Include payment for the full amount of services requested;
Not to exceed $250 without club approval.

Total Services Requested $_____

NOTE: Frames will be chosen from the Pearle Vision "Lions Club" Collection Only.

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.

Pearle Vision Clinic Location :

Club Name: _____ District: _____

Club Representative: _____ Position Held: _____

E-mail: _____ Cell Phone: _____

Address: _____ City: _____ Zip_____