cwbgroup

CWB Form 504E/2024-03

NDT Personnel Visual Acuity Form

SECTION 1: IDENTIFICATION OF APPLICANT (Please print):

Applicant's Name: _____ Registration #: _____

☐ Application for Certification ☐ Renewal of Certification ☐ Recertification ☐ Annual Near Vision Acuity

*Email: _____

*I understand that all official communication moving forward will be sent to me via electronic mail (email) and it is my responsibility to advise the CWB Group of any changes in my email address. _____ initials

SECTION 2: NEAR VISION REQUIREMENTS:

Near vision acuity testing shall be administered by a licensed physician, nurse, ophthalmologist or optometrist; or by another trained professional who is approved and documented by a Level 3 personnel acting on behalf of the employer. Near vision acuity must be completed annually.

Near vision acuity shall permit reading a minimum of Jaeger number 1 or Times Roman N 4.5 or equivalent letters (having a height of 1.6 mm) at not less than 30 cm with one or both eyes, either corrected or uncorrected. Submission of a prescription for corrective lenses in lieu of this form is not acceptable.

SECTION 3: DECLARATION OF PERSON ADMINISTERING THE NEAR VISION TEST:

This is to certify that I, _____ administered a test of visual acuity
Full Name (please print)

to _____ on _____
Applicant's Name (please print) Examination Date (MM / DD / YYYY)

I also certify that the applicant: (check applicable box)

Meets the vision requirements in Section 2 without ☐
Meets the vision requirements in Section 2 with ☐
Does not meet the vision requirements in Section 2 ☐

Check one of the following:

☐ Optometrist ☐ Ophthalmologist ☐ Other (complete Section 5)
☐ Registered Nurse ☐ Licensed Physician

Address: _____
Email: _____

Signature of Examiner: _____ Tel. #: _____

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SECTION 4: COLOUR VISION REQUIREMENTS:

Colour vision and/or grey scale perception verification(s) shall be administered by a licensed physician, nurse, ophthalmologist or optometrist; or by another trained professional who is approved and documented by a Level 3 personnel acting on behalf of the employer. The vision examination must have been performed no more than 12 months from the date of receipt of this form by the CWB.

It is required that colour vision and/or grey scale perception be sufficient for the individual to be able to distinguish and differentiate between the colours or shades of grey used in the NDT methods/techniques concerned as specified by the employer.

The colour vision test shall either confirm that the individual has acceptable colour vision without restriction or shall state any limitation(s) on colour perception.

The Ishihara 24 plate test is an example of a suitable colour vision test.

SECTION 5: DECLARATION OF PERSON ADMINISTERING THE COLOUR VISION TEST:

This is to certify that I, _____ administered a test of visual acuity
Full Name (please print)

to _____ on _____
Applicant's Name (please print) Examination Date (MM / DD / YYYY)

I also certify that the applicant: (check applicable box)

Meets the vision requirements in Section 4 ☐ Meets Section 4 requirements with restrictions below: ☐

Does not meet the vision requirements in Section 4 ☐

Check one of the following: _____

☐ Optometrist ☐ Ophthalmologist ☐ Other (complete Section 6)

☐ Registered Nurse ☐ Licensed Physician

Address: _____

Email: _____

Signature of Examiner: _____ Tel. #: _____

SECTION 6: DECLARATION OF APPROVAL & DOCUMENTATION BY A LEVEL 3:

This is to certify that I, _____ approved the personnel performing vision tests
Full Name (please print)

for _____ on _____
Applicant's Name (please print) Examination Date (MM / DD / YYYY)

Level 3 Registration Number: _____ Signature: _____

FOR CWB USE ONLY:

Reviewed by: _____ Date: _____

PLEASE ATTACH COMPLETED RECORD TO YOUR APPLICATION AND SEND TO CWB.
RETAIN A COPY FOR YOUR FILE.