



WASHOE COUNTY LIONS
SIGHT CONSERVATION COMMITTEE

Eye Sight Assistance Application

APPLICATIONS ARE REVIEWED THE SECOND WEDNESDAY OF EVERY MONTH.

SERVICES AVAILABLE ONE TIME ONLY IN 12 MONTHS. LOST GLASSES WILL NOT BE REPLACED.

(Note: Application must be fully completed for consideration; an incomplete application will be returned.
Applications for minors must include parent/guardian employment and total household income.)

Applicant's name: _____ Date: _____

Age of Applicant: _____ Email: _____

Present address: _____

City, State, ZIP: _____

Number of people in household: _____ Phone: _____

School name (students only): _____

How long have you lived in Washoe or Lyon county? _____

What is your employer's name? _____

Do you have **vision** insurance? (Medicaid, Medicare, child welfare, etc.) Yes No

What is your household monthly income, including alimony, child support, etc.? _____

If you have no income, please explain why? _____

When was your last eye examination by a doctor of optometry or ophthalmologist? _____

If you wear glasses now, when did you receive your last pair of eyeglasses? _____

Eyeglasses for: Reading Distance

Name of your eye doctor: _____

Referred by: _____

Signature of parent/guardian or adult applicant: _____

Please mail COMPLETED application to: WCLSCC, P.O. Box 11935, Reno, NV 89510
Email: wclsc@gmail.com

Acuity: L: _____ R: _____ **Both:** _____