
PRIOR APPROVAL FOR PAYMENT OF STUDENT SERVICES

Student Name: _____

School: _____

Referring LCS Employee: _____

Appointment Date: _____

Appointment Time: _____

| Service Description | Expense | Party Responsible for Payment |
|----------------------|---------|-------------------------------|
| Frames/Lenses | | |
| Exams | | |
| Other/Repair | | |
| Total Expense | | |

Service Provider: Precision Vision
 Address: 707 S. Horner Blvd.
 Sanford, NC 27330
 Telephone Number: (919)-774-1700
 Fax Number: (919)-775-4232

Referring LCS Employee's Signature
Date

Director's Signature
Date