

ORT6022 LOW VISION

MANAGER’S CONSENT FORM

Manager’s first name:

Manager’s surname: Title:

Place of Work:

I confirm that my manager has agreed to my working in the Low Vision Clinic to gain practical experience. I understand that if I change my job or am unable to undertake practical work for any reason, I will not be able to complete the assessment for the module.

Signed: Date:

Print Name:

Please complete and return by email to: orthoptics@sheffield.ac.uk