



UNIVERSITY OF MASSACHUSETTS LOWELL
Laser Worker Authorization

Name: _____ Date of Birth: _____
Work Phone: _____ Email: _____
Any history of eye problems (e.g. detached retina) Yes: _____ No: _____
If yes please explain: _____

Laboratory Information

Authorized User _____ Dept. _____
Description of Work: _____
Location _____ Telephone#: _____

Training

Laser Safety Training Check Here
Type: Computer based new user training
Type: Talked with a radiation safety representative
Type: Lab specific safety training

I have been instructed and I understand the following regarding above work (initial each applicable item):

- 1. The health risks of working with lasers.
2. I will review and follow my laser specific standard Operating procedures.
3. The applicable provisions of UML, state, and federal regulations, including the UML Laser Safety Guide.
4. My responsibility to wear appropriate and functional PPE.
5. The appropriate response to any Laser accident.

The above worker has received instructions and on-the-job/site specific training to safely perform the work described above. They have been shown the laser specific standard operating procedures and I will ensure that they are followed.

Signature (Authorized User)

Health Physics Certification:

Health Physics Approval: _____ Date: _____